

California Code of Regulations

Title 10. Investment

Chapter 12. California Health Benefit Exchange (§ 6400 et seq.)

Add Section 6408:

Article 2. Abbreviations and Definitions

§ 6408. Abbreviations.

The following abbreviations shall apply to this article:

<u>ACO</u>	<u>Accountable Care Organization</u>
<u>APTC</u>	<u>Advance Payments of Premium Tax Credit</u>
<u>CAHPS</u>	<u>Consumer Assessment of Healthcare Providers and Systems</u>
<u>CalHEERS</u>	<u>California Healthcare Eligibility, Enrollment, and Retention System</u>
<u>CFR</u>	<u>Code of Federal Regulations</u>
<u>CHIP</u>	<u>Children's Health Insurance Program</u>
<u>CSR</u>	<u>Cost-Sharing Reduction</u>
<u>DHCS</u>	<u>Department of Health Care Services</u>
<u>DHS</u>	<u>U.S. Department of Homeland Security</u>
<u>EPO</u>	<u>Exclusive Provider Organization</u>
<u>FPL</u>	<u>Federal Poverty Level</u>
<u>FOHC</u>	<u>Federally-Qualified Health Center</u>
<u>HEDIS</u>	<u>Health Effectiveness Data and Information Set</u>
<u>HHS</u>	<u>U.S. Department of Health and Human Services</u>
<u>HIPAA</u>	<u>Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)</u>
<u>HMO</u>	<u>Health Maintenance Organization</u>
<u>HAS</u>	<u>Health Savings Account</u>
<u>IAP</u>	<u>Insurance Affordability Program</u>
<u>IPA</u>	<u>Independent Practice Association</u>
<u>IRC</u>	<u>Internal Revenue Code of 1986</u>
<u>IRS</u>	<u>Internal Revenue Services</u>
<u>LEP</u>	<u>Limited English Proficient</u>

<u>MAGI</u>	<u>Modified Adjusted Gross Income</u>
<u>MEC</u>	<u>Minimum Essential Coverage</u>
<u>POS</u>	<u>Point of Service</u>
<u>QHP</u>	<u>Qualified Health Plan</u>
<u>SHOP</u>	<u>Small Business Health Options Program</u>
<u>SSA</u>	<u>Social Security Administration</u>
<u>SSN</u>	<u>Social Security Number</u>
<u>TIN</u>	<u>Taxpayer Identification Number</u>
<u>USC</u>	<u>United States Code</u>

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100501, 100502, and 100503, Government Code; 45 CFR Sections 155.20 and 155.300.

Repeal Section 6410:

Section 6410: Definitions

~~As used in this Chapter, the following terms shall mean:~~

~~340B Entity: A “covered entity” as defined in Public Health Service Act Section 340B(a)(4), 42 U.S.C. 256b(a)(4).~~

~~Accountable Care Organization (ACO): A voluntary group of physicians, hospitals and other health care providers that are willing to assume responsibility and some financial risk for the care of a clearly defined patient population attributed to them on the basis of patients’ use of primary care services. Characteristics of an ACO may include robust use of electronic health record infrastructure, defined quality metrics including outcomes, shared savings formulas affecting reimbursement, coordinated care requirements or pay for performance reimbursement components.~~

~~Alternate Benefit Plan Design: A QHP proposed benefit plan design which features different cost sharing requirements than the Exchange’s Standardized Qualified Health Plan Designs.~~

~~Benefit Plan Requirements: Coverage that provides for all of the following as under 45 CFR § 156.20:~~

- ~~(a) — The essential health benefits as described in Section 1302(b) of the Affordable Care Act;~~
- ~~(b) — Cost sharing limits as described in Section 1302(c) of the Affordable Care Act; and~~
- ~~(c) — A bronze, silver, gold, or platinum level of coverage as described in Section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in Section 1302(e) of the Affordable Care Act.~~

Bidder: A Health Insurance Issuer seeking to enter into a Qualified Health Plan contract.

Board: The Board of the California Health Benefit Exchange, established by Government Code 100500.

CAHPS: Consumer Assessment of Healthcare Providers and Systems. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care. CAHPS develops surveys that are taken by hospitals, health plans, and home health agencies and are designed to measure patient experience with these entities.

CalHEERS: The California Healthcare Eligibility, Enrollment and Retention System, created pursuant to Government Code 100502 and 100503, as well as 42 U.S.C. 18031, to enable enrollees and prospective enrollees of QHPs to obtain standardized comparative information on the QHPs as well as apply for eligibility, enrollment, and reenrollment in the Exchange.

California Health Benefit Exchange or Exchange: The entity established pursuant to Government Code 100500. The Exchange also does business as and may be referred to as "Covered California."

Certified QHP: Any QHP that is selected by the Exchange and has entered into a contract with the Exchange for the provision of health insurance coverage for enrollees who purchase health insurance coverage through the Individual and/or Small Business Health Options Program (SHOP) Exchanges.

Cost share: Any expenditure required by or on behalf of an enrollee with respect to receipt of Essential Health Benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

Day: A calendar day unless a business day is specified.

EPO: An Exclusive Provider Organization, as defined in California Code of Regulations, title 10, Section 2699.6000(r).

Essential Community Providers: Providers that serve predominantly low-income, medically underserved individuals, as defined in 45 C.F.R. 156.235.

Essential Health Benefits: The benefits listed in 42 U.S.C. 18022, Health and Safety Code 1367.005, and Insurance Code 10112.27.

Evidence-Based Medicine: The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.

Exchange Evaluation Team: The team selected by the Exchange to conduct the QHP bid response evaluation by consensus and assess whether the response is responsive and may proceed to the evaluation of the response.

Executive Director: The Executive Director of the Exchange.

Federally Qualified Health Center (FQHC): Federally Qualified Health Center has the same meaning as that term is defined in Section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)).

Geographic Service Area: A defined geographic area within the State of California that a proposed QHP proposes to serve and is approved by the applicable State Health Insurance Regulator to serve.

Health Insurance Issuer: Health Insurance Issuer has the same meaning as that term is defined in 42 U.S.C. 300gg-91 and 45 C.F.R. 144.103. Also referred to as “Health Issuer” or “Issuer.”

Health Maintenance Organization (HMO): A Health Care Service Plan (as that term is defined in Health & Safety Code 1345) holding a current license from and in good standing with the California Department of Managed Health Care.

HEDIS: Health Effectiveness Data and Information Set, a set of managed care performance measures developed and maintained by the National Committee for Quality Assurance.

HSA: Health Savings Account, as defined in 26 U.S.C. 223.

Independent Practice Association (IPA): An IPA is a legal entity organized and directed by physicians in private practice to negotiate contracts with Health Insurance Issuers on their behalf.

Individual and Small Business Health Options Program (SHOP) Exchanges: The programs administered by the Exchange pursuant to California Government Code § 100500 et seq. (2010 Cal. Stat. 655 (AB 1602) and 2010 Cal. Stat. 659 (SB 900)), 42 U.S.C. 18031(b) of the federal Patient Protection Affordable Care Act and other applicable laws to furnish and to pay for health insurance plans for Qualified Individuals and Qualified Employers.

Ineligible Bidder: A prospective Bidder who is not in good standing with the applicable State Health Insurance Regulator, or does not meet the qualifications for consideration as a Qualified Health Plan under this Chapter, or has not provided complete responses or conforming responses to the QHP solicitation.

Initial Open Enrollment Period: The initial period in which Qualified Individuals may enroll in QHPs, from October 1, 2013 to March 31, 2014, subject to 45 C.F.R. 155.410(b).

Internet Web Portal: The web portal made available through a link on the Exchange’s website, www.healthexchange.ca.gov, through which the Exchange will make the Solicitation available

electronically and which can be accessed directly at <https://www.proposaltech.com/app.php/login>.

Level of Coverage: One of four standardized actuarial values and the catastrophic level of coverage as defined in 42 U.S.C. 18022(d) and (e).

Medical Group: A group of physicians and other health care providers who have organized themselves to provide services to a defined patient population or contract with a Health Issuer or hospital.

Network or Provider Network: The collection of Providers who have entered into contracts with a Health Insurance Issuer which govern payment and other terms of the business relationship between the Health Insurance Issuer and the Providers. Provider Networks are integral to an Issuer's proposed QHPs.

POS: Point of Service as defined in Health & Safety Code 1374.60.

Patient-Centered Medical Home: a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.

Preferred Provider Organization: A network of medical doctors, hospitals, and other health care providers who have contracted with a Health Insurance Issuer to provide health care at reduced rates to the Issuer's insureds or enrollees.

Provider or Network Provider: An appropriately credentialed or licensed individual, facility, agency, institution, organization or other entity that has a written agreement with a proposed QHP Bidder for the delivery of health care services.

QHP Issuer: A Health Insurance Issuer whose proposed QHP has been selected and certified by the Exchange for offering to Qualified Individuals and Qualified Employers purchasing health insurance coverage through the Exchange

Qualified Employer: Qualified Employer has the same meaning as that term is defined in 42 U.S.C. 18032(f)(2) and 45 C.F.R. 155.710.

Qualified Health Plan (QHP): Qualified Health Plan (QHP) has the same meaning as that term is defined in Patient Protection and Affordable Care Act Section 1301, 42 U.S.C. 18021. If a Standalone Dental Plan is offered through the Exchange, another health plan offered through the Exchange shall not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the standalone plan under 42 U.S.C. 18022(b)(1)(J).

Qualified Health Plan Solicitation or Solicitation: The California Health Benefit Exchange 2012-2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, as amended December 28, 2012.

~~Qualified Individual: Qualified Individual is an individual who meets the requirements of 42 U.S.C. 18032(f)(1) and 45 C.F.R. 155.305(a).~~

~~Quality Assurance: Processes used by proposed QHPs to monitor and improve the quality of care provided to enrollees.~~

~~Rating Region: The geographic regions for purposes of rating defined in Health & Safety Code 1357.512 and Insurance Code 10753.14.~~

~~SHOP Plan Year: A 12-month period beginning with the Qualified Employer's effective date of coverage.~~

~~Solicitation Official: The Exchange's single point of contact for the Solicitation.~~

~~Standalone Dental Plan: A plan providing limited scope dental benefits as defined in 26 U.S.C. 9832(e)(2)(A), including the pediatric dental benefits meeting the requirements of 42 U.S.C. 18022(b)(1)(J).~~

~~Standardized QHP Benefit Design(s): Benefit plan designs that the Board determines to be standard pursuant to Government Code 100504(c), as described in Solicitation Section II.B.1.~~

~~State Health Insurance Regulators: The Department of Managed Health Care and California Department of Insurance.~~

~~State Mandates: Health care benefits required to be covered by California statutes.~~

~~Telemedicine: The ability of physicians and patients to connect via technology other than through virtual interactive physician/patient capabilities, especially enabling rural and out-of-area patients to be seen by specialists remotely.~~

~~Two-Tiered Network: A benefit design with two in-network benefit levels. Standard plan cost-share is applied to most cost-effective network with higher cost-share allowed for more expensive in-network choice. Actuarial value is based on likely overall use of tiered networks.~~

~~Value-Based Insurance Design: Value-Based Benefit Design includes explicit use of plan incentives to encourage enrollee adoption of one or more of the following: appropriate use of high-value services, including certain prescription drugs and preventive services and use of high-performance providers who adhere to evidence-based treatment guidelines.~~

Add Section 6410

§ 6410. Definitions.

As used in this Chapter, the following terms shall mean:

340B Entity: A “covered entity” as defined in Public Health Service Act Section 340B(a)(4), [42 U.S.C. 256b\(a\)\(4\)](#).

Accountable Care Organization (ACO): A voluntary group of physicians, hospitals and other health care providers that are willing to assume responsibility and some financial risk for the care of a clearly defined patient population attributed to them on the basis of patients' use of primary care services. Characteristics of an ACO may include robust use of electronic health record infrastructure, defined quality metrics including outcomes, shared savings formulas affecting reimbursement, coordinated care requirements or pay for performance reimbursement components.

Alternate Benefit Plan Design: A QHP proposed benefit plan design which features different cost-sharing requirements than the Exchange's Standardized Qualified Health Plan Designs.

Adoption Taxpayer Identification Number (ATIN): An ATIN as defined in 26 CFR § 301.6109-3(a).

Advance Payments of Premium Tax Credit (APTC): Payment of the tax credits authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with Section 1412 of the Affordable Care Act.

Affordable Care Act (ACA): The federal Patient Protection and Affordable Care Act of 2010 (Pub.L. 111–148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Pub.L. 111–152).

Agent or Broker: A person or entity licensed by the State as an agent, broker or insurance producer.

Annual Open Enrollment Period: The period each year during which a qualified individual may enroll or change coverage in a QHP through the Exchange, as specified in Section 6502 of Article 5 of this chapter.

Applicable Children's Health Insurance Program (CHIP) MAGI–based Income Standard: The applicable income standard as defined at 42 CFR § 457.310(b)(1), as applied under the State plan adopted in accordance with title XXI of the Social Security Act, or waiver of such plan and as certified by the State CHIP Agency in accordance with 42 CFR § 457.348(d), for determining eligibility for child health assistance and enrollment in a separate child health program.

Applicable Medi-Cal Modified Adjusted Gross Income (MAGI)-based income standard: The same standard as “applicable modified adjusted gross income standard,” as defined at 42 CFR § 435.911(b), as applied under the State plan adopted in accordance with title XIX of the Social Security Act, or waiver of such plan, and as certified by the DHCS in accordance with 42 CFR § 435.1200(b)(2) for determining eligibility for Medi-Cal.

Applicant: An applicant means:

(a) An individual who is seeking eligibility for him or herself through an application submitted to the Exchange, excluding those individuals seeking eligibility for an exemption from the shared responsibility payment for not maintaining minimum essential coverage pursuant to Section 6454 of Article 4 of this chapter, or transmitted to the Exchange by an agency administering an insurance affordability program for at least one of the following:

(i) Enrollment in a QHP through the Exchange; or

(ii) Medi-Cal and CHIP.

(b) An employer or employee seeking eligibility for enrollment in a QHP through the SHOP, where applicable.

Application Filer: An applicant; an adult who is in the applicant's household, as defined in 42 CFR § 435.603(f), or family, as defined in 26 U.S.C. 36B(d) and 26 CFR § 1.36B-1(d); an authorized representative; or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant; excluding those individuals seeking eligibility for an exemption pursuant to Section 6454 of Article 4 of this chapter.

Authorized Representative: Any person or entity who has been designated, in writing, by the applicant to act on his/her behalf or individuals who have appropriate power of attorney or legal conservatorship.

Benefit Plan Requirements: Coverage that provides for all of the following as under [45 CFR § 156.20](#):

(a) The essential health benefits as described in Section 1302(b) of the Affordable Care Act;

(b) Cost-sharing limits as described in Section 1302(c) of the Affordable Care Act; and

(c) A bronze, silver, gold, or platinum level of coverage as described in Section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in Section 1302(e) of the Affordable Care Act.

Benefit Year: A calendar year for which a health plan provides coverage for health benefits.

Bidder: A Health Insurance Issuer seeking to enter into a Qualified Health Plan contract.

Board: The Board of the California Health Benefit Exchange, established by [Government Code 100500](#).

Consumer Assessment of Healthcare Provider (CAHPS): The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of consumers' experiences with health care. CAHPS develops surveys that are taken by hospitals, health plans, and home health agencies and are designed to measure patient experience with these entities.

California Health Eligibility, Enrollment and Retention System (CalHEERS): The California Healthcare Eligibility, Enrollment and Retention System, created pursuant to [Government Code 100502](#) and [100503](#), as well as [42 U.S.C. 18031](#), to enable enrollees and prospective enrollees of QHPs to obtain standardized comparative information on the QHPs as well as apply for eligibility, enrollment, and reenrollment in the Exchange.

California Health Benefit Exchange or Exchange: The entity established pursuant to [Government Code 100500](#). The Exchange also does business as and may be referred to as “Covered California.”

Catastrophic Plan: A health plan described in Section 1302(e) of the Affordable Care Act.

Certified QHP: Any QHP that is selected by the Exchange and has entered into a contract with the Exchange for the provision of health insurance coverage for enrollees who purchase health insurance coverage through the Individual and/or Small Business Health Options Program (SHOP) Exchanges.

Cost-share or Cost-sharing: Any expenditure required by or on behalf of an enrollee with respect to receipt of Essential Health Benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

Cost-Sharing Reduction (CSR): Reductions in cost-sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange.

Day: A calendar day unless a business day is specified.

Educated Health Care Consumer: An individual as defined in Section 1304(e) of the Affordable Care Act.

Eligible Employer-sponsored Plan: A plan as defined in Section 5000A(f)(2) of IRC (26 U.S.C. § 5000A(f)(2)).

Employee: An individual as defined in Section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91).

Employer: A person as defined in Section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91), except that such term includes employers with one or more employees. All persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of IRC (26 U.S.C. § 414) are treated as one employer.

Employer Contributions: Any financial contributions towards an employer sponsored health plan, or other eligible employer-sponsored benefit made by the employer including those made by salary reduction agreement that is excluded from gross income.

Enrollee: A qualified individual or qualified employee enrolled in a QHP.

Exclusive Provider Organization (EPO): An Exclusive Provider Organization, as defined in [California Code of Regulations, title 10, Section 2699.6000\(r\)](#).

Essential Community Providers: Providers that serve predominantly low-income, medically underserved individuals, as defined in [45 CFR 156.235](#).

Essential Health Benefits: The benefits listed in [42 U.S.C. 18022](#), [Health and Safety Code 1367.005](#), and [Insurance Code 10112.27](#).

Evidence-Based Medicine: The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.

Exchange Evaluation Team: The team selected by the Exchange to conduct the QHP bid response evaluation by consensus and assess whether the response is responsive and may proceed to the evaluation of the response.

Exchange Service Area: The entire geographic area of the State of California.

Executive Director: The Executive Director of the Exchange.

Federally-Qualified Health Center (FQHC): Federally-Qualified Health Center has the same meaning as that term is defined in Section 1905(1)(2)(B) of the Social Security Act ([42 U.S.C. 1396d\(1\)\(2\)\(B\)](#)).

Federal Poverty Level (FPL): The most recently published Federal poverty level, updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 U.S.C. § 9902(2), as of the first day of the annual open enrollment period for coverage in a QHP through the Exchange, as specified in Section 6502 of Article 5 of this chapter.

Geographic Service Area: A defined geographic area within the State of California that a proposed QHP proposes to serve and is approved by the applicable State Health Insurance Regulator to serve.

Grandfathered Health Plan: A health plan as defined in 45 CFR § 147.140.

Group Health Plan: A group health plan within the meaning of 45 CFR § 146.145(a).

Health Insurance Coverage: Coverage as defined in 45 CFR § 144.103.

Health Insurance Issuer: Health Insurance Issuer has the same meaning as that term is defined in [42 U.S.C. 300gg-91](#) and [45 CFR 144.103](#). Also referred to as “Health Issuer” or “Issuer.”

Health Maintenance Organization (HMO): A Health Care Service Plan (as that term is defined in [Health & Safety Code 1345](#)) holding a current license from and in good standing with the California Department of Managed Health Care.

Health plan: A plan as defined in Section 1301(b)(1) of the Affordable Care Act.

Health Effectiveness Data and Information Set (HEDIS): A set of managed care performance measures developed and maintained by the National Committee for Quality Assurance.

Health Savings Account (HSA): Health Savings Account, as defined in [26 U.S.C. 223](#).

Independent Practice Association (IPA): An IPA is a legal entity organized and directed by physicians in private practice to negotiate contracts with Health Insurance Issuers on their behalf.

Insurance Affordability Program (IAP): A program as defined in 42 CFR § 435.4.

Indian: An Indian, as defined in Section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub.L. 93-638), means a person who is a member of an Indian tribe.

Indian Tribe: An Indian tribe, as defined in Section 4(e) of the Indian Self-Determination and Education Assistance Act (Pub.L. 93-638), means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. § 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Individual and Small Business Health Options Program (SHOP) Exchanges: The programs administered by the Exchange pursuant to [California Government Code § 100500 et seq.](#) (2010 Cal. Stat. 655 (AB 1602) and 2010 Cal. Stat. 659 (SB 900)), [42 U.S.C. 18031\(b\)](#) of the federal Patient Protection Affordable Care Act and other applicable laws to furnish and to pay for health insurance plans for Qualified Individuals and Qualified Employers.

Individual Market: A market as defined in Section 1304(a)(2) of the Affordable Care Act.

Ineligible Bidder: A prospective Bidder who is not in good standing with the applicable State Health Insurance Regulator, or does not meet the qualifications for consideration as a Qualified Health Plan under this Chapter, or has not provided complete responses or conforming responses to the QHP solicitation.

Initial Open Enrollment Period: The initial period in which Qualified Individuals may enroll in QHPs, from October 1, 2013 to March 31, 2014, subject to [45 CFR 155.410\(b\)](#).

Internet Web Portal: The web portal made available through a link on the Exchange's website, www.healthexchange.ca.gov, through which the Exchange will make the Solicitation available electronically and which can be accessed directly at <https://www.proposaltech.com/app.php/login>.

Large Employer: Beginning before January 1, 2016, an employer who, in connection with a group health plan with respect to a calendar year and a plan year, employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. Effective for plan years beginning on or after January 1, 2016, the number of employees shall be determined using the method set forth in section 4980H(c)(2) of IRC (26 U.S.C. § 4980H(c)(2)).

Lawfully Present: a non-citizen individual as defined in 42 CFR § 435.4.

Level of Coverage: One of four standardized actuarial values and the catastrophic level of coverage as defined in [42 U.S.C. 18022\(d\)](#) and [\(e\)](#).

MAGI-based income: Income as defined in 42 CFR § 435.603(e).

Medical Group: A group of physicians and other health care providers who have organized themselves to provide services to a defined patient population or contract with a Health Issuer or hospital.

Minimum Essential Coverage (MEC): Coverage as defined in Section 5000A(f) of IRC (26 U.S.C. § 5000A(f)) and in 26 CFR § 1.36B-2(c).

Minimum Value: Minimum value, when used to describe coverage in an eligible employer-sponsored plan, means that the plan meets the requirements with respect to coverage of the total allowed costs of benefits set forth in Section 36B(c)(2)(C)(ii) of IRC (26 U.S.C. § 36B(c)(2)(C)(ii)) and in 26 CFR § 1.36B-2(c)(3)(vi).

Modified Adjusted Gross Income (MAGI): Income as defined in Section 36B(d)(2)(B) of IRC (26 U.S.C. § 36B(d)(2)(B)) and in 26 CFR § 1.36B-1(e)(2).

Network or Provider Network: The collection of Providers who have entered into contracts with a Health Insurance Issuer which govern payment and other terms of the business relationship between the Health Insurance Issuer and the Providers. Provider Networks are integral to an Issuer's proposed QHPs.

Non-citizen: An individual who is not a citizen or national of the United States, in accordance with Section 101(a)(3) of the Immigration and Nationality Act.

Patient-Centered Medical Home: a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.

Plan Year: A consecutive 12 month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year or otherwise.

Plain Language: Language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follow other best practices of plain language writing.

Point of Service (POS): Point of Service as defined in [Health & Safety Code 1374.60](#).

Preferred Provider Organization (PPO): A network of medical doctors, hospitals, and other health care providers who have contracted with a Health Insurance Issuer to provide health care at reduced rates to the Issuer's insureds or enrollees.

Premium Payment Due Date: A date no earlier than the fourth remaining business day of the month prior to the month in which coverage becomes effective.

Provider or Network Provider: An appropriately credentialed or licensed individual, facility, agency, institution, organization or other entity that has a written agreement with a proposed QHP Bidder for the delivery of health care services.

QHP Issuer: A Health Insurance Issuer whose proposed QHP has been selected and certified by the Exchange for offering to Qualified Individuals and Qualified Employers purchasing health insurance coverage through the Exchange

Qualified employee: An individual who is employed by a qualified employer and has been offered health insurance coverage by such qualified employer through the SHOP.

Qualified Employer: Qualified Employer has the same meaning as that term is defined in [42 U.S.C. 18032\(f\)\(2\)](#) and [45 CFR 155.710](#).

Qualified Health Plan (QHP): Qualified Health Plan (QHP) has the same meaning as that term is defined in Patient Protection and Affordable Care Act Section 1301, [42 U.S.C. 18021](#). If a Standalone Dental Plan is offered through the Exchange, another health plan offered through the Exchange shall not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the standalone plan under [42 U.S.C. 18022\(b\)\(1\)\(J\)](#).

Qualified Health Plan Solicitation or Solicitation: The California Health Benefit Exchange 2012-2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond, as amended December 28, 2012.

Qualified Individual: Qualified Individual is an individual who meets the requirements of [42 U.S.C. 18032\(f\)\(1\)](#) and [45 CFR 155.305\(a\)](#).

Qualifying coverage in an eligible employer-sponsored plan: Coverage in an eligible employer-sponsored plan that meets the affordability and minimum value standards specified in Section 36B(c)(2)(C) of IRC (26 U.S.C. § 36B(c)(2)(C)) and in 26 CFR § 1.36B-2(c)(3).

Quality Assurance: Processes used by proposed QHPs to monitor and improve the quality of care provided to enrollees.

Rating Region: The geographic regions for purposes of rating defined in [Health & Safety Code 1357.512](#) and [Insurance Code 10753.14](#).

Reasonably compatible: The difference or discrepancy between the information that the Exchange obtained through electronic data sources, provided by the applicant, or other information in the records of the Exchange and an applicant's attestation does not impact the eligibility of the applicant, including the amount of advance payments of the premium tax credit or category of cost-sharing reductions.

SHOP: A Small Business Health Options Program operated by the Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs.

SHOP Plan Year: A 12-month period beginning with the Qualified Employer's effective date of coverage.

Small employer: An employer as defined in Section 1357.500(k) of California Health and Safety Code.

Small group market: A group market as defined in Section 1304(a)(3) of the Affordable Care Act.

Special enrollment period: A period during which a qualified individual or enrollee who experiences certain qualifying events, as specified in Section 6504(a) of Article 5 of this chapter, may enroll in, or change enrollment in, a QHP through the Exchange outside of the initial and annual open enrollment periods.

Solicitation Official: The Exchange's single point of contact for the Solicitation.

Standalone Dental Plan: A plan providing limited scope dental benefits as defined in [26 U.S.C. 9832\(c\)\(2\)\(A\)](#), including the pediatric dental benefits meeting the requirements of [42 U.S.C. 18022\(b\)\(1\)\(J\)](#).

Standardized QHP Benefit Design(s): Benefit plan designs that the Board determines to be standard pursuant to [Government Code 100504\(c\)](#), as described in Solicitation Section II.B.1.

State Health Insurance Regulators: The Department of Managed Health Care and California Department of Insurance.

State Mandates: Health care benefits required to be covered by California statutes.

Tax dependent: A dependent as defined in Section 152 of IRC (26 U.S.C. § 152).

Tax filer: An individual, or a married couple, who indicates that he, she, or the couple expects:

(a) To file an income tax return for the benefit year, in accordance with 26 U.S.C. §§ 6011, 6012, and implementing regulations;

(b) If married (within the meaning of 26 CFR § 1.7703-1), to file a joint tax return for the benefit year;

(c) That no other taxpayer will be able to claim him, her, or the couple as a tax dependent for the benefit year; and

(d) That he, she, or the couple expects to claim a personal exemption deduction under Section 151 of IRC on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Telemedicine: The ability of physicians and patients to connect via technology other than through virtual interactive physician/patient capabilities, especially enabling rural and out-of-area patients to be seen by specialists remotely.

Two-Tiered Network: A benefit design with two in-network benefit levels. Standard plan cost-share is applied to most cost-effective network with higher cost-share allowed for more expensive in-network choice. Actuarial value is based on likely overall use of tiered networks.

Value-Based Insurance Design: Value-Based Benefit Design includes explicit use of plan incentives to encourage enrollee adoption of one or more of the following: appropriate use of high-value services, including certain prescription drugs and preventive services and use of high-performance providers who adhere to evidence-based treatment guidelines.

NOTE: Authority: Sections 100502, 100503, 100504, and 100505, Government Code.

Reference: Sections 100501, 100502, 100503, and 100505, Government Code; 45 CFR Sections 155.20 and 155.300.

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Title 10. Investment

Chapter 12. California Health Benefit Exchange (§ 6400 et seq.)

Article 4. General Provisions.

§ 6450. Meaning of Words.

Words shall have their usual meaning unless the context or a definition clearly indicates a different meaning. “Shall” means mandatory. “May” means permissive. “Should” means suggested or recommended.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100501, 100502, and 100503, Government Code.

§ 6452. Accessibility and Readability Standards.

- (a) All applications, including the single streamlined application described in Section 6470 of Article 5 of this chapter, forms, notices, and correspondence provided to the applicants and enrollees by the Exchange and QHP issuers shall conform to the standards outlined in paragraphs (b) and (c) of this section.
- (b) Information shall be provided to applicants and enrollees in plain language, as defined in Section 6410 of Article 2 of this chapter, and all written correspondence shall also:
 - (1) Whenever administratively feasible, be formatted in such a way that it can be understood at the sixth-grade level and no more than the ninth-grade level of readability; Be formatted in such a way that it can be understood at the ninth-grade level;
 - (2) Not contain technical language beyond a ninth-grade level or print smaller than 12 point; and
 - (3) Not contain language that minimizes or contradicts the information being provided.
- (c) Information shall be provided to applicants and enrollees in a manner that is accessible and timely to:
 - (1) Individuals living with disabilities through the provision of auxiliary aids and services at no cost to the individual, including accessible Web sites, in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.
 - (2) Individuals who are limited English proficient through the provision of language services at no cost to the individual, including:
 - (A) Oral interpretation or written translations; and

(B) Taglines in non-English languages indicating the availability of language services.

- (3) Inform individuals of the availability of the services described in paragraphs (b)(1) and (2) of this section and how to access such services.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR Sections 155.20 and 155.205.

§ 6454. Exemption from Individual Responsibility. (Discussion Item Only)

(a) For purposes of this section, the following terms have the following meaning:

- (1) Applicant means an individual who is seeking an exemption for him or herself through an application submitted to the Exchange.
 - (2) Application filer means an applicant, an individual who is liable for the shared responsibility payment in accordance with Section 5000A(b) of IRC for an applicant, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant.
 - (3) Certificate of exemption is a certification attesting that, for purposes of the individual responsibility penalty specified in Section 5000A of IRC (26 U.S.C. § 5000A), the individual is exempt from the individual responsibility requirement and the penalty imposed by such section.
 - (4) Exemption means an exemption from the shared responsibility payment.
 - (5) Incarcerated means confined, after the disposition of charges, in a jail, prison, or similar penal institution or correctional facility.
 - (6) Indian tribe has the same meaning as it does in Section 6410 of Article 2 of this chapter.
 - (7) Shared responsibility payment has the same meaning as in Section 5000A(b) of IRC.
- (b) For the purposes of this section, any attestation that an applicant is to provide under this section may be made by the application filer on behalf of the applicant.
- (c) For purposes of this section, the information through electronic data sources, other information provided by the applicant, or other information in the records of the Exchange shall be considered to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not impact the eligibility of the applicant for the exemption or exemptions for which he or she applied.
- (d) Information, including notices, forms, and applications, shall be provided to applicants in accordance with the accessibility and readability standards specified in Section 6452.

- (e) An individual who meets one or more of the categories of exemptions described in paragraph (f) of this section for at least one day of the month may:
- (1) Request from the Exchange a certificate of exemption only for religious conscience, membership in a health care sharing ministry, membership in an Indian tribe, incarceration, or hardship, as specified in paragraphs (f)(3), (4), (5), (7), and (8) of this section; or
 - (2) Claim on the individual's Federal income tax return for the applicable year an exemption for inability to afford coverage, household income below the applicable income tax return filing threshold, not being lawfully present, or short coverage gaps, as specified in paragraphs (f)(1), (2), (6), and (9) of this section.
- (f) The following individuals shall be exempt from the individual responsibility requirements and the imposed penalty:
- (1) Individuals who cannot afford coverage through the Exchange or their employers.
 - (A) An individual cannot afford coverage in a month if the individual's required contribution, determined on an annual basis, for MEC for the month exceeds eight percent of such individual's household income for the taxable year. An individual's household income is increased by any amount of the required contribution made through a salary reduction arrangement that is excluded from gross income.
 - (B) The required contribution for an employee who is eligible to purchase coverage under an eligible employer-sponsored plan sponsored by the employee's employer is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost self-only coverage.
 - (C) The required contribution for an individual who is eligible for coverage under an eligible employer-sponsored plan because of a relationship to an employee and for whom a personal exemption deduction under Section 151 of IRC (26 U.S.C. § 151) is claimed on the employee's Federal income tax return (related individual) is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost family coverage that would cover the employee and all nonexempt related individuals included in the employee's family.
 - (D) The required contribution for an individual who is ineligible for coverage under an eligible employer-sponsored plan is the annual premium for the lowest cost bronze plan available in the individual market through the Exchange serving the rating area in which the individual resides (without regard to whether the individual purchased a QHP through the Exchange), reduced by the amount of the premium tax credit allowable under Section 36B of IRC (26 U.S.C. § 36B) for the taxable year (determined as if the individual was covered for the entire taxable year by a QHP offered through the Exchange).

- (2) Individuals with annual household income below tax filing threshold, as specified in Section 6012(a)(1) of IRC (26 U.S.C. § 6012(a)(1)). The filing threshold for an individual who is properly claimed as a dependent by another taxpayer is equal to the other taxpayer's applicable filing threshold.
- (3) Members of a federally recognized religious sect or division thereof, as described in Section 1402(g)(1) of IRC (26 U.S.C. § 1402(g)(1)), and adherents of established tenets or teachings of such sect or division as described in such section.
- (4) Members of a health care sharing ministry, which is an organization described in Section 501(c)(3) and exempt from taxation under Section 501(a) of IRC (26 U.S.C. § 501(a), (c)(3)) and has the following characteristics:
 - (A) Members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed;
 - (B) Members of which retain membership even after they develop a medical condition;
 - (C) That (or a predecessor of which) has been in existence at all times since December 31, 1999;
 - (D) Members of which have shared medical expenses continuously and without interruption since at least December 31, 1999; and
 - (E) That conducts an annual audit performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and makes the annual audit report available to the public upon request.
- (5) Members of Indian tribes, as defined in Section 6410 of Article 2 of this chapter.
- (6) Individuals who are not citizens or nationals of the United States for any day during the month and are either:
 - (A) Nonresident aliens, as defined in Section 7701(b)(1)(B) of IRC (26 U.S.C. § 7701(b)(1)(B)), for the taxable year that includes the month; or
 - (B) Individuals who are not lawfully present in the United States on any day in the month.
- (7) Individuals who are incarcerated, other than incarceration pending the disposition of charges.
- (8) Individuals who, for a month or months during which, are determined to have suffered a hardship with respect to the capability to obtain coverage under a QHP because:

- (A) They have experienced financial or domestic circumstances, including unexpected natural or human-caused events, such that they have a significant, unexpected increase in essential expenses;
 - (B) The expense of purchasing MEC would have caused them to experience serious deprivation of food, shelter, clothing or other necessities; or
 - (C) They have experienced other factors similar to those described in paragraphs (f)(8)(A) and (B) of this section that prevented them from obtaining MEC.
- (9) Individuals with short coverage gap are exempt for any month the last day of which is included in a continuous period of less than three months in which they are not covered by MEC. For the purposes of short coverage gap:
- (A) The length of a continuous period shall be determined without regard to the calendar years in which months included in that period occur;
 - (B) If the individual does not have MEC for a continuous period of three or more months, none of the months included in the continuous period is treated as included in a short coverage gap;
 - (C) If a calendar year includes more than one short coverage gap, the exemption provided by this paragraph only applies to the earliest short coverage gap; and
 - (D) An individual is treated as having MEC for a month in which the individual is exempt under any of paragraphs (f)(1) through (8) of this section.
- (g) For the duration of a single exemption, the following rules shall apply.
- (1) Except as specified in paragraphs (g)(2), (3), and (4) of this section, the Exchange shall provide a certificate of exemption only for the calendar year in which an applicant submitted an application for such exemption.
 - (2) In case of an exemption for religious conscience:
 - (A) The Exchange shall grant the certificate of exemption to an applicant who meets the standards provided in paragraph (f)(3) of this section for a month on a continuing basis, until the month after the month of the individual's 18th birthday, or until such time that an individual reports that he or she no longer meets the standards provided in paragraph (f)(3).
 - (B) If the Exchange granted a certificate of exemption in this category to an applicant prior to him or her reaching the age of 18, the Exchange shall send such an applicant

a notice upon reaching the age of 18 informing the applicant that he or she shall submit a new exemption application if seeking to maintain the certificate of exemption.

- (3) In case of an exemption for membership in an Indian tribe, the Exchange shall grant the exemption to an applicant who meets the standards for this exemption, as specified in paragraph (f)(5) of this section, for a month on a continuing basis, until such time that the applicant reports that he or she no longer meets such standards.
- (4) In case of an exemption for hardship, an applicant shall be determined eligible for an exemption:
 - (A) For a month or months during which the applicant has experienced the circumstances specified in paragraph (f)(8) of this section;
 - (B) For a calendar year if:
 - i. The applicant, or another individual the applicant attests will be included in the applicant's family, is unable to afford coverage for such calendar year in accordance with the standards specified in paragraph (f)(1) of this section; and
 - ii. The applicant applies for this exemption prior to the last date on which he or she could enroll in a QHP through the Exchange for the calendar year for which the exemption is requested;
 - (C) For a calendar year if the applicant, as well as one or more employed members of his or her family, has been determined eligible for affordable self-only employer-sponsored coverage pursuant to paragraph (f)(1) of this section through their respective employers for one or more months during the calendar year, but the aggregate cost of employer-sponsored coverage for all the employed members of the family exceeds 8 percent of household income for that month or those months; or
 - (D) For a calendar year if the applicant was not required to file an income tax return for such calendar year because his or her gross income was below the filing threshold, but who nevertheless filed to receive a tax benefit, claimed a dependent with a filing requirement, and as a result, had household income exceeding the applicable return filing threshold described in paragraph (f)(2) of this section.
- (5) The Exchange shall provide an exemption prospectively or retrospectively for religious conscience and membership in an Indian tribe.
- (6) The Exchange shall only provide an exemption retrospectively for incarceration and membership in a health care sharing ministry.
- (h) An applicant's eligibility for exemptions shall be determined in accordance with the following procedures:

- (1) Except as specified in paragraph (h)(2) of this section, an applicant or an application filer requesting a certificate of exemption for one or more of the categories of exemptions specified in paragraph (e)(1) of this section shall submit all information, documentation, and declarations required on the exemption application (placeholder for the No. & date version of the HHS-provided exemption application) to the Exchange. An exemption application may be filed through any of the channels available for the submission of an application, as described in Section 6470(e) of Article 5 of this chapter. The following rules shall apply to the collection of Social Security Numbers.
- (A) An applicant who has a SSN shall provide such number to the Exchange.
 - (B) Except as specified in paragraph (h)(1)(C) of this section, an individual who is not seeking an exemption for himself or herself shall not be required to provide a SSN.
 - (C) An application filer shall provide the SSN of a tax filer who is not an applicant only if an applicant attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be utilized for verification of household income and family size for an exemption for hardship under paragraphs (f)(8) and (g)(4)(B) of this section that requires such verification.
- (2) If an individual submits a single, streamlined application described in Section 6470 of Article 5 of this chapter and then requests an exemption:
- (A) The information collected for purposes of the eligibility determination for enrollment in a QHP and for IAPs shall also be used in making the exemption eligibility determination; and
 - (B) Duplicate information shall not be requested.
- (3) The Exchange shall:
- (A) Accept the application from an applicant or an application filer;
 - (B) Provide the tools to file an application;
 - (C) Transmit, via secure electronic interface, all information provided as a part of the application that initiated the eligibility determination, and any information obtained or verified by the Exchange to HHS promptly and without undue delay, in a manner and timeframe as specified by HHS, for verification and eligibility determination for the categories of exemptions specified in paragraph (e)(1) of this section;
 - (D) Adhere to the eligibility determination made by HHS for one or more of the categories of exemptions specified in paragraph (e)(1) of this section;

- (E) Provide written notice to an applicant of any eligibility determination made by HHS within five business days from the date of the HHS eligibility redetermination; and
- (F) In the case of a HHS determination that an applicant is eligible for any of the exemptions specified in paragraph (e)(1) of this section:
 - i. Issue a certificate of exemption to the individual who requested it;
 - ii. Include in the eligibility determination notice specified in paragraph (h)(3)(E) of this section the exemption certificate number for the purposes of tax administration; and
 - iii. Transmit to the IRS, via secure electronic interface and at such time and in such manner as specified by the IRS, the individual's name, SSN, exemption certificate number, and any other information required in guidance published by the Commissioner of the IRS in accordance with 26 CFR § 601.601(d)(2).
- (4) The determination of whether an individual is eligible for any of the exemptions specified in paragraph (e)(2) of this section shall be made exclusively by IRS through the tax filing process.
- (5) Except for the exemptions for religious conscience and membership in an Indian tribe described in paragraphs (f)(3) and (5) of this section, after December 31 of a given calendar year, the Exchange:
 - (A) Shall not accept an application for an exemption for months for such calendar year; and
 - (B) Shall provide information to individuals regarding the process for claiming an exemption through the tax filing process.
- (i) An applicant's eligibility for exemptions shall be redetermined during a calendar year in accordance with the following procedures:
 - (1) An individual who has a certificate of exemption from the Exchange shall be required to report to the Exchange any changes with respect to the eligibility standards for the exemption, as specified in paragraph (f) of this section, within 30 days of such change through any of the channels available for the submission of an exemption application, as specified in paragraph (h)(1) of this section.
 - (2) The Exchange shall transmit, via secure electronic interface, the reported changes to HHS promptly and without undue delay, in a manner and timeframe as specified by HHS, for verification and eligibility redetermination.

- (3) The Exchange shall provide written notice to an applicant of any eligibility redetermination made by HHS based on a reported change within five business days from the date of the eligibility redetermination.
- (4) The Exchange shall provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes, to an individual who has a certificate of exemption and has elected to receive electronic notifications, unless he or she has declined to receive such notifications.
- (j) An individual who requests or receives a certificate of exemption from the Exchange shall have the right to appeal an eligibility determination or redetermination for an exemption. An individual who seeks an appeal shall request such an appeal directly to HHS.
- (k) The Exchange shall include the notice of the right to appeal and instructions regarding how to file an appeal with HHS in any notification issued in accordance with paragraphs (h)(3)(E) and (i)(3) of this section.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR §§ 155.600–155.635, as proposed on Feb. 1, 2013.

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Article 5. Application, Eligibility, and Enrollment Process for the Individual Exchange

§ 6470. Application. (Discussion Item Only)

- (a) The Exchange shall use a single, streamlined application to determine eligibility and to collect information necessary for:
- (1) Enrollment in a QHP;
 - (2) APTC;
 - (3) CSR; and
 - (4) MAGI Medi-Cal or CHIP.
- (b) To apply for any of the programs listed in paragraph (a) of this section, an applicant or an application filer shall submit all information, documentation, and declarations required on the single, streamlined application, as specified in paragraphs (c) and (d) of this section, and shall sign and date the application.
- (c) An applicant or an application filer shall provide the following information on the single, streamlined application: [Placeholder for the application data elements]
- (1) “Reserved.”
- (d) An applicant or an application filer shall provide the following declarations on the single, streamlined application: [Placeholder for the declarations/acknowledgements on the application]
- (1) “Reserved.”
- (e) An application filer may file an application through one of the following channels:
- (1) The Exchange’s Internet Web site;
 - (2) Telephone;
 - (3) Facsimile;
 - (4) Mail; or
 - (5) In person.
- (f) The Exchange shall accept an application and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during the year.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR §§ 155.310, 155.405.

§ 6472. Eligibility Requirements for Enrollment in a QHP through the Exchange.

- (a) An applicant shall meet the requirements of this section, except for the requirements specified in paragraph (f), regardless of the applicant's eligibility for APTC or CSR. For purposes of this section, an applicant includes all individuals listed on the application who are seeking enrollment in a QHP through the Exchange.
- (b) An applicant who has a SSN shall provide his or her SSN to the Exchange.
- (c) An applicant shall be a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought.
- (d) An applicant shall not be incarcerated, other than incarceration pending the disposition (judgment) of charges.
- (e) An applicant shall meet one of the following applicable residency standards:
 - (1) For an individual who is age 21 and over, is not living in an institution as defined in Title 22, Division 3, Sections 50047 through 50052.5, is capable of indicating intent, and is not receiving Supplemental Security Income/State Supplemental Program payments as defined in Title 22, Division 3, Section 50095, the service area of the Exchange of the individual is the service areas of the Exchange in which he or she is living and:
 - (A) Intends to reside, including without a fixed address; or
 - (B) Has entered with a job commitment or is seeking employment (whether or not currently employed).
 - (2) For an individual who is under the age of 21, is not living in an institution as defined in Title 22, Division 3, Sections 50047 through 50052.5, is not eligible for Medi-Cal based on receipt of assistance under title IV–E of the Social Security Act, is not emancipated, and is not receiving Supplemental Security Income/State Supplemental Program payments as defined in Title 22, Division 3, Section 50095, the Exchange service area of the individual is:
 - (A) The service area of the Exchange in which he or she resides, including without a fixed address; or

- (B) The service area of the Exchange of a parent or caretaker, established in accordance with paragraph (e)(1) of this section, with whom the individual resides.
- (3) For an individual who is not described in paragraphs (e)(1) or (2) of this section, the Exchange shall apply the residency requirements described in Title 22, Division 3, Section 50320 with respect to the service area of the Exchange.
- (4) Special rule for tax households with members in multiple Exchange service areas.
 - (A) Except as specified in paragraph (e)(4)(B) of this section, if all of the members of a tax household are not within the same Exchange service area, in accordance with the applicable standards in paragraphs (e)(1), (2), and (3) of this section, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the tax filers meets the residency standard.
 - (B) If both spouses in a tax household enroll in a QHP through the same Exchange, a tax dependent may choose to enroll in a QHP either through that Exchange or through the Exchange that services the area in which the dependent meets a residency standard described in paragraphs (e)(1), (2), or (3) of this section.
- (5) The Exchange shall not deny or terminate an individual's eligibility for enrollment in a QHP through the Exchange if the individual meets the standards in paragraph (e)(1)–(4) of this section but for a temporary absence from the service area of the Exchange and intends to return when the purpose of the absence has been accomplished, unless another Exchange verifies that the individual meets the residency standard of such Exchange.
- (f) The eligibility standards specified in this paragraph shall only apply to the eligibility determination for enrollment through the Exchange in a QHP that is a catastrophic plan, as defined in Section 1302(e) of the Affordable Care Act.
 - (1) The Exchange shall determine an applicant eligible for enrollment in a catastrophic QHP through the Exchange if the applicant:
 - (A) Has not attained the age of 30 before the beginning of the plan year; or
 - (B) Has a certification in effect for any plan year that the applicant is exempt from the requirement to maintain MEC under section 5000A of IRC (26 U.S.C. § 5000A) by reason of:

- i. Section 5000A(e)(1) of IRC (26 U.S.C. § 5000A(e)(1)) relating to individuals without affordable coverage; or
- ii. Section 5000A(e)(5) of IRC (26 U.S.C. § 5000A(e)(5)) relating to individuals with hardships.

(2) APTC shall not be available to support enrollment in a catastrophic QHP through the Exchange.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.305.

§ 6474. Eligibility Requirements for APTC and CSR.

- (a) Those individuals who apply to receive APTC and CSR shall meet the eligibility requirements of this section in addition to the requirements of Section 6472.
- (b) For purposes of this section, household income has the meaning given the term in Section 36B(d)(2) of IRC (26 U.S.C. § 36B(d)(2)) and in 26 CFR § 1.36B-1(e).
- (c) Eligibility for APTC.
 - (1) A tax filer shall be eligible for APTC if:
 - (A) Tax filer is expected to have a household income of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and
 - (B) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse:
 - i. Meets the requirements for eligibility for enrollment in a QHP through the Exchange, as specified in Section 6472;
 - ii. Is not eligible for MEC, with the exception of coverage in the individual market, in accordance with section 36B(c)(2)(B) and (C) of IRC (26 U.S.C. § 36B(c)(2)(B), (C)) and 26 CFR § 1.36B-2(c); and
 - iii. Is enrolled in a QHP that is not a catastrophic plan through the Exchange.

- (2) A non-citizen tax filer who is lawfully present and ineligible for Medi-Cal by reason of immigration status shall be eligible for APTC if:
- (A) Tax filer meets the requirements specified in paragraph (c)(1) of this section, except for paragraph (c)(1)(A);
 - (B) Tax filer is expected to have a household income of less than 100 percent of the FPL for the benefit year for which coverage is requested; and
 - (C) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse, is a non-citizen who is lawfully present and ineligible for Medi-Cal by reason of immigration status, in accordance with section 36B(c)(1)(B) of IRC (26 U.S.C. § 36B(c)(1)(B)) and in 26 CFR § 1.36B-2(b)(5).
- (3) Tax filer shall not be eligible for APTC if:
- (A) HHS notifies the Exchange, as part of the verification process described in Sections 6482 through 6486, that APTC was made on behalf of the tax filer (or either spouse if the tax filer is a married couple) for a year for which tax data would be used to verify household income and family size in accordance with Section 6482(d) and (e);
 - (B) Tax filer (or his or her spouse) did not comply with the requirement to file an income tax return for that year, as required by 26 U.S.C. §§ 6011, 6012, and implementing regulations; and
 - (C) The APTC was not reconciled for that period.
- (4) The APTC amount shall be calculated in accordance with section 36B of IRC (26 U.S.C. § 36B) and 26 CFR § 1.36B-3.
- (5) An application filer shall provide the SSN of a tax filer who is not an applicant only if an applicant attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be used to verify household income and family size.

(d) Eligibility for CSR.

- (1) An applicant shall be eligible for CSR if he or she:

- (A) Meets the eligibility requirements for enrollment in a QHP through the Exchange, as specified in Section 6472;
 - (B) Meets the requirements for APTC, as specified in paragraph (c) of this section; and
 - (C) Is expected to have a household income that does not exceed 250 percent of the FPL for the benefit year for which coverage is requested.
- (2) The Exchange may only provide CSR to an enrollee who is not an Indian if he or she is enrolled through the Exchange in a silver-level QHP, as defined by section 1302(d)(1)(B) of the Affordable Care Act.
- (3) The Exchange shall use the following eligibility categories for CSR when making eligibility determinations under this section:
- (A) An individual who is expected to have a household income:
 - i. Greater than or equal to 100 percent of the FPL and less than or equal to 150 percent of the FPL for the benefit year for which coverage is requested, or
 - ii. Less than 100 percent of the FPL for the benefit year for which coverage is requested, if he or she is eligible for APTC under paragraph (c)(2) of this section;
 - (B) An individual is expected to have a household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL for the benefit year for which coverage is requested; and
 - (C) An individual who is expected to have a household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL for the benefit year for which coverage is requested.
- (4) If an enrollment in a QHP under a single family policy covers two or more individuals, the Exchange shall deem the individuals under such family policy to be collectively eligible only for the last category of eligibility listed below for which all the individuals covered by the family policy would be eligible:
- (A) Not eligible for CSR;
 - (B) Section 6494(a)(3) and (4) – Special CSR eligibility standards and process for Indians regardless of income;

- (C) Paragraph (d)(3)(C) of this section;
- (D) Paragraph (d)(3)(B) of this section;
- (E) Paragraph (d)(3)(A) of this section; and
- (F) Section 6494(a)(1) and (2) – Special CSR eligibility standards and process for Indians with household incomes under 300 percent of FPL.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.305.

§ 6476. Eligibility Determination Process

- (a) An applicant may request an eligibility determination only for enrollment in a QHP through the Exchange.
- (b) An applicant's request for an eligibility determination for an IAP shall be deemed a request for all IAPs.
- (c) The following special rules relate to APTC.
 - (1) An enrollee may accept less than the full amount of APTC for which he or she is determined eligible.
 - (2) To be determined eligible for APTC, a tax filer shall make the following attestations as applicable:
 - (A) He or she will file an income tax return for the benefit year, in accordance with 26 U.S.C. §§ 6011, 6012, and implementing regulations;
 - (B) If married (within the meaning of 26 CFR 1.7703–1), he or she will file a joint tax return for the benefit year;
 - (C) No other taxpayer will be able to claim him or her as a tax dependent for the benefit year; and
 - (D) He or she will claim a personal exemption deduction on his or her tax return for the applicants identified as members of his or her family, including the tax filer and his or her spouse, in accordance with Section 6482(d).
- (d) If the Exchange determines an applicant eligible for Medi-Cal or CHIP, the Exchange shall notify DHCS and transmit all information from the records of the Exchange to DHCS, ~~promptly and without undue delay~~ within three business days from the date of the eligibility determination, that is necessary for DHCS to provide the applicant with coverage.

- (e) An applicant's eligibility shall be determined ~~promptly and without undue delay~~ within 10 calendar days from the date the Exchange receives the applicant's paper application.
- (f) Upon making an eligibility determination, the Exchange shall implement the eligibility determination under this section for enrollment in a QHP through the Exchange, APTC, and CSR as follows:
- (1) For an initial eligibility determination, in accordance with the dates specified in Section 6502(c) and (f) and Section 6504(g) and (h), as applicable; or
 - (2) For a redetermination, in accordance with the dates specified in Section 6496(k), (l) and (m) and Section 6498(l), as applicable.
- (g) The Exchange shall provide ~~timely~~ written notice to an applicant of any eligibility determination made in accordance with this article within five business days from the date of the eligibility determination.
- (h) The Exchange shall notify an employer that an employee has been determined eligible for APTC and CSR upon determination that an employee is eligible for APTC and CSR. Such notice shall:
- (1) Identify the employee;
 - (2) Indicate that the employee has been determined eligible for APTC and CSR;
 - (3) Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the tax penalty assessed under section 4980H of IRC; and
 - (4) Notify the employer of the right to appeal the determination.
- (i) If an applicant who is determined eligible for enrollment in a QHP does not select a QHP within his or her enrollment periods, specified in Sections 6502 and 6504, and seeks a new enrollment period:
- (1) Prior to the date on which his or her eligibility would have been redetermined in accordance with Section 6498 had he or she enrolled in a QHP:
 - (A) The applicant shall attest as to whether information affecting his or her eligibility has changed since his or her most recent eligibility determination before his or her eligibility shall be determined for an enrollment period; and
 - (B) Any changes the applicant reports shall be processed in accordance with the procedures specified in Section 6496.

- (2) On or after the date on which his or her eligibility would have been redetermined in accordance with Section 6498 had he or she enrolled in a QHP, the applicant's eligibility for an enrollment period shall be determined in accordance with the procedures specified in Section 6498.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.310.

§ 6478. Verification Process Related to Eligibility Requirements for Enrollment in a QHP through the Exchange.

- (a) The Exchange shall verify or obtain information as provided in this section to determine whether an applicant meets the eligibility requirements specified in Section 6472 relating to the eligibility requirements for enrollment in a QHP through the Exchange.
- (b) Verification of SSN.
 - (1) For any individual who provides his or her SSN to the Exchange, the Exchange shall transmit the SSN and other identifying information to HHS, which will submit it to the SSA.
 - (2) If the Exchange is unable to verify an individual's SSN through the SSA, the Exchange shall follow the procedures specified in Section 6492, except that the Exchange shall provide the individual with a period of 90 days from the date on which the notice described in Section 6492(a)(2)(A) is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the SSA. The date on which the notice is received means five days after the date on the notice, unless the individual demonstrates that he or she did not receive the notice within the five-day period.
- (c) Verification of citizenship, status as a national, or lawful presence.
 - (1) For an applicant who attests to citizenship and has a SSN, the Exchange shall transmit the applicant's SSN and other identifying information to HHS, which will submit it to the SSA.
 - (2) For an applicant who has documentation that can be verified through the DHS and who attests to lawful presence, or who attests to citizenship and for whom the Exchange cannot substantiate a claim of citizenship through the SSA, the Exchange shall transmit information from the applicant's documentation and other identifying information to HHS, which will submit necessary information to the DHS for verification.

- (3) For an applicant who attests to citizenship, status as a national, or lawful presence, and for whom the Exchange cannot verify such attestation through the SSA or the DHS, the Exchange shall follow the inconsistencies procedures specified in Section 6492, except that the Exchange shall provide the applicant with a period of 90 days from the date on which the notice described in Section 6492 (a)(2)(A) is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the SSA or the DHS, as applicable. The date on which the notice is received means five days after the date on the notice, unless the applicant demonstrates that he or she did not receive the notice within the five-day period

(d) Verification of residency.

- (1) Except as provided in paragraphs (d)(2) and (3) of this section, the Exchange shall ~~verify~~ accept an applicant's attestation that he or she meets the residency standards of Section 6472(e) without further verification.as follows:

~~(A) Except as provided in paragraphs (d)(2) and (3) of this section, accept his or her attestation without further verification; or~~

~~(B) Examine HHS-approved electronic data sources that are available to the Exchange.~~

- (2) If information provided by an applicant regarding residency is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange shall examine information in HHS-approved data sources that are available to the Exchange.
- (3) If the information in ~~such~~ data sources specified in paragraph (d)(2) of this section is not reasonably compatible with the information provided by the applicant, the Exchange shall follow the procedures specified in Section 6492. Evidence of immigration status may not be used to determine that an applicant is not a resident of the Exchange service area.

(e) Verification of incarceration status.

- (1) The Exchange shall verify an applicant's attestation that he or she meets the requirements of 6472(b) by:
 - (A) Relying on any HHS-approved electronic data sources that are available to the Exchange; or

- (B) Except as provided in paragraph (e)(2) of this section, if a HHS-approved data source is unavailable, accepting the applicant's attestation without further verification.
- (2) If an applicant's attestation is not reasonably compatible with information from HHS-approved data sources described in paragraph (e)(1)(A) of this section or other information provided by the applicant or in the records of the Exchange, the Exchange shall follow the inconsistencies procedures specified in Section 6492.
- (f) Verification related to eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan.
- (1) The Exchange shall verify an applicant's attestation that he or she meets the requirements of 6472(f) by:
- (A) Verifying the applicant's attestation of age as follows:
- i. Except as provided in paragraph (f)(1)(A)(ii) of this section, the Exchange shall accept the applicant's attestation of age without further verification.
- ii. If information regarding age is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange shall examine information in HHS-approved data sources that are available to the Exchange.
- (B) Verifying that an applicant has received a certificate of exemption as described in Section 6472(f)(1)(B).
- (2) To the extent that the Exchange is unable to verify the information required to determine eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan as described in paragraph (f)(1) of this section, the Exchange shall follow the procedures specified in Section 6492, except for Section 6492(a)(4).

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.315.

§ 6480. Verification of Eligibility for MEC other than through an Eligible Employer-Sponsored Plan Related to Eligibility Determination for APTC and CSR.

- (a) The Exchange shall verify whether an applicant is eligible for MEC other than through an eligible employer-sponsored plan, Medi-Cal, or CHIP, using information obtained from the HHS.

- (b) The Exchange shall verify whether an applicant has already been determined eligible for coverage through Medi-Cal or CHIP, using information obtained from the DHCS.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502, 100503, and 100504, Government Code; 45 CFR § 155.320.

§ 6482. Verification of Family Size and Household Income Related to Eligibility Determination for APTC and CSR.

- (a) For purposes of this section, “family size” and “household income” have the meanings given the terms in Section 36B(d)(1) and (2) of IRC (26 U.S.C. § 36B(d)(1)) and in 26 CFR § 1.36B-1(d), (e).
- (b) For all individuals whose income is counted in calculating a tax filer's household income, in accordance with section 36B(d)(2) of IRC (26 U.S.C. § 36B(d)(2)) and 26 CFR § 1.36B-1(e), and for whom the Exchange has a SSN or a TIN, the Exchange shall request tax return data regarding MAGI and family size from HHS.
- (c) If the identifying information for one or more individuals does not match a tax record on file with the IRS, the Exchange shall proceed in accordance with the procedures specified in Section 6492.
- (d) An applicant's family size shall be verified in accordance with the following procedures.
 - (1) An applicant shall attest to the individuals that comprise a tax filer's family for APTC and CSR.
 - (2) If an applicant attests that the information described in paragraph (b) of this section represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR shall be determined based on the family size data in paragraph (b) of this section.
 - (3) Except as specified in paragraph (d)(4) of this section, the tax filer's family size for APTC and CSR shall be verified by accepting an applicant's attestation without further verification if:
 - (A) The data described in paragraph (b) of this section is unavailable; or
 - (B) The applicant attests that a change in family size has occurred, or is reasonably expected to occur, and so the data described in paragraph (b) of this section does not represent an accurate projection of the tax filer's family size for the benefit year for which coverage is requested.
 - (4) If Exchange finds that an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the application filer for the

family or in the records of the Exchange, with the exception of the data described in paragraph (b) of this section, the applicant's attestation shall be verified using data obtained through other electronic data sources. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the applicant shall provide additional documentation requested by the Exchange to support the attestation, in accordance with Section 6492.

- (e) An applicant's annual household income shall be verified in accordance with the following procedures.
 - (1) The annual household income of the family described in paragraph (d)(1) shall be computed based on the tax return data described in paragraph (b) of this section.
 - (2) An applicant shall attest to a tax filer's projected annual household income.
 - (3) If an applicant's attestation indicates that the information described in paragraph (e)(1) of this section represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the tax filer's eligibility for APTC and CSR shall be determined based on the household income data in paragraph (e)(1) of this section.
 - (4) If the data described in paragraph (b) of this section is unavailable, or an applicant attests that a change in household income has occurred, or is reasonably expected to occur, and so it does not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the applicant shall attest to the tax filer's projected household income for the benefit year for which coverage is requested.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.320.

§ 6484. Verification Process for Increases in Household Income Related to Eligibility Determination for APTC and CSR.

- (a) Except as provided in paragraph (b) of this section, the Exchange shall accept the applicant's attestation for the tax filer's family without further verification if:
 - (1) An applicant attests, in accordance with Section 6482(e)(2), that a tax filer's annual household income has increased, or is reasonably expected to increase, from the data described in Section 6482(e)(1) for the benefit year for which the applicant(s) in the tax filer's family are requesting coverage; and
 - (2) The Exchange has not verified the applicant's MAGI-based income through the process specified in ~~Section 6488(e)~~ Medicaid regulations at 42 CFR § 435.945, 42 CFR § 435.948, and 42 CFR § 435.952 and CHIP regulations at 42 CFR § 457.380 to be within the applicable Medi-Cal or CHIP MAGI-based income standard.

- (b) If the Exchange finds that an applicant's attestation of a tax filer's annual household income is not reasonably compatible with other information provided by the application filer or available to the Exchange ~~in accordance with Section 6488(d)~~, the applicant's attestation shall be verified using data the Exchange obtained through electronic data sources.
- (c) If the data sources described in paragraph (b) of this section are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the applicant shall provide additional documentation requested by the Exchange to support the attestation, in accordance with Section 6492.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.320.

§ 6486. Alternate Verification Process for APTC and CSR Eligibility Determination for Decreases in Annual Household Income or If Tax Return Data Is Unavailable.

- (a) A tax filer's annual household income shall be determined based on the alternate verification procedures described in paragraphs (b) and (c) of this section if:
 - (1) An applicant attests to projected annual household income in accordance with Section 6482(e)(2);
 - (2) The tax filer does not meet the criteria specified in Section 6484;
 - (3) The applicants in the tax filer's family have not established MAGI-based income, through the process specified in ~~Section 6488(e)~~ Medicaid regulations at 42 CFR § 435.945, 42 CFR § 435.948, and 42 CFR § 435.952 and CHIP regulations at 42 CFR § 457.380, that is within the applicable MAGI-based income standard; and
 - (4) One of the following conditions is met:
 - (A) The IRS does not have tax return data that may be disclosed under Section 6103(l)(21) of IRC (26 U.S.C. § 6102(l)(21)) for the tax filer that is at least as recent as the calendar year two years prior to the calendar year for which APTC and CSR would be effective;
 - (B) The applicant attests that the tax filer's applicable family size has changed, or is reasonably expected to change (or the members of the tax filer's family have changed, or are reasonably expected to change), for the benefit year for which the applicants in his or her family are requesting coverage;
 - (C) The applicant attests that a change in circumstances has occurred, or is reasonably expected to occur, and so the tax filer's annual household income has decreased, or is reasonably expected to decrease, from the data described in Section 6482(b) for the benefit year for which the applicants in his or her family are requesting coverage;

- (D) The applicant attests that the tax filer's filing status has changed, or is reasonably expected to change, for the benefit year for which the applicants in his or her family are requesting coverage; or
 - (E) An applicant in the tax filer's family has filed an application for unemployment benefits.
- (b) If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (a) of this section and the applicant's attestation to projected annual household income, as described in Section 6482(e)(2), is no more than ten percent below the annual household income computed in accordance with Section 6482(e)(1), the applicant's attestation shall be accepted without further verification.
- (c) If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (a) of this section and the applicant's attestation to projected annual household income, as described in Section 6482(e)(2), is greater than ten percent below the annual household income computed in accordance with Section 6482(e)(1), or if the tax data described in Section 6482(b) is unavailable:
- (1) The applicant's attestation of the tax filer's projected annual household income for the tax filer shall be verified by:
 - (A) Using annualized data from the MAGI-based income sources specified in ~~Section 6488(d)~~ Medicaid regulations at 42 CFR § 435.948(a);
 - (B) Using other HHS-approved electronic data sources; or
 - (C) Following the procedures specified in Section 6492(a)(1) through (4) if electronic data are unavailable or do not support an applicant's attestation;
 - (2) The applicant shall not be eligible for APTC or CSR if:
 - (A) An applicant has not responded to a request for additional information from the Exchange following the 90-day period described in paragraph (c)(1)(C) of this section; and
 - (B) The data sources specified in Section 6482(b) and ~~6488(d)~~ Medicaid regulations at 42 CFR § 435.948(a) indicate that an applicant in the tax filer's family is eligible for Medi-Cal or CHIP.
 - (3) If, at the conclusion of the period specified in paragraph (c)(1)(C) of this section, the Exchange remains unable to verify the applicant's attestation, the Exchange shall:
 - (A) Determine the applicant's eligibility based on the information described in Section 6482(e)(1);

- (B) Notify the applicant of such determination in accordance with the notice requirements specified in Section 6476(g); and
 - (C) Implement such determination in accordance with the effective dates specified in Section 6496(k) through (m).
- (4) If, at the conclusion of the period specified in paragraph (c)(1)(C) of this section, the Exchange remains unable to verify the applicant's attestation for the tax filer and the information described in Section 6482(e)(1) is unavailable, the Exchange shall:
- (A) Determine the tax filer ineligible for APTC and CSR;
 - (B) Notify the applicant of such determination in accordance with the notice requirements specified in Section 6476(g); and
 - (C) Discontinue any APTC and CSR in accordance with the effective dates specified in Section 6496(k) through (m).

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.320.

§ 6488. Verification Process for MAGI-Based Medi-Cal and CHIP. (Discussion Item Only)

- (a) Except as provided in paragraph (b) of this section, an applicant's household size shall be verified by accepting the applicant's attestation without further verification, in accordance with 42 CFR § 435.945(a).
- (b) If an applicant's attestation to the individuals that comprise his or her household for Medi-Cal and CHIP is not reasonably compatible with other information provided by the application filer for the applicant or in the records of the Exchange, the applicant's attestation shall be verified using data obtained through electronic data sources.
- (c) If the data sources described in paragraph (b) of this section are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the applicant shall provide additional documentation to support the attestation, in accordance with 42 CFR § 435.952.
- (d) For all individuals whose income is counted in calculating an applicant's household income in accordance with 42 CFR § 435.603(d), data regarding MAGI-based income shall be requested through CalHEERS in accordance with 42 CFR § 435.948(a).
- (e) An applicant's MAGI-based income, within the meaning of 42 CFR § 435.603(d), for the applicant's household shall be verified in accordance with the procedures specified in Medicaid regulations at 42 CFR § 435.945, 42 CFR § 435.948, and 42 CFR § 435.952 and CHIP regulations at 42 CFR § 457.380.

- (f) For purposes of determining eligibility for Medi-Cal or CHIP for an applicant who does not attest to being a citizen or a national, the applicant's immigration status shall be verified through CalHEERS, as required by Medicaid regulations at 42 CFR § 435.406 and CHIP regulations at 42 CFR 457.320(b).

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.320.

§ 6490. Verifications of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-Sponsored Plan Related to Eligibility Determination for APTC and CSR. (Discussion Item Only)

- (a) The Exchange shall rely on a verification process performed by HHS for verification of enrollment, and eligibility for qualifying coverage, in an eligible employer-sponsored plan.
- (b) The Exchange shall send the notices described in Section 6476(g) and (h).
- (c) The Exchange shall provide all relevant application information to HHS through a secure, electronic interface, promptly and without undue delay, in a manner and timeframe as specified by HHS.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.320, as proposed on Jan. 22, 2013.

§ 6492. Inconsistencies.

- (a) Except as otherwise specified in this Article, for an applicant whose attestations are inconsistent with the data obtained by the Exchange from available data sources, or for whom the Exchange cannot verify information required to determine eligibility for enrollment in a QHP, or for APTC and CSR, including when electronic data is required in accordance with this section but not available, the Exchange:
- (1) Shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer;
 - (2) If unable to resolve the inconsistency through the process described in paragraph (a)(1) of this section, shall:
 - (A) Provide notice to the applicant regarding the inconsistency; and
 - (B) Provide the applicant with a period of 90 days from the date on which the notice described in paragraph (a)(2)(A) of this section is sent to the applicant to either

present satisfactory documentary evidence through ~~the channels available for the submission of an application, as described in Section 6470(d), except by telephone the Exchange's Internet website, by mail, by facsimile, or in person,~~ or otherwise resolve the inconsistency.

- (3) May extend the period described in paragraph (a)(2)(B) of this section for an applicant if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period.
- (4) During the period described in paragraph (a)(2)(B) of this section, shall:
 - (A) Proceed with all other elements of eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP if an applicant is otherwise qualified; and
 - (B) Ensure that APTC and CSR are provided within this period on behalf of an applicant who is otherwise qualified for such payments and reductions, as described in Section 6474, provided that the tax filer attests to the Exchange that he or she understands that any APTC paid on his or her behalf are subject to reconciliation.
- (5) If, after the period described in paragraph (a)(2)(B) of this section, the Exchange remains unable to verify the attestation, shall:
 - (A) Determine the applicant's eligibility based on the information available from the data sources specified in Sections 6478 through 6492, unless such applicant qualifies for the exception provided under paragraph (b) of this section, and notify the applicant of such determination in accordance with the notice requirements specified in Section 6476(g), including notice that the Exchange is unable to verify the attestation; and
 - (B) Effectuate the determination specified in paragraph (a)(5)(A) of this section no earlier than 10 days after and no later than 30 days after the date on which the notice in paragraph (a)(5)(A) of this section is sent.
- (b) The Exchange shall provide an exception, on a case-by-case basis, to accept an applicant's attestation as to the information which cannot otherwise be verified and the applicant's explanation of circumstances as to why the applicant does not have documentation if:
 - (1) An applicant does not have documentation with which to resolve the inconsistency through the process described in paragraph (a)(2) of this section because such documentation does not exist or is not reasonably available;

- (2) The Exchange is unable to otherwise resolve the inconsistency for the applicant; and
- (3) The inconsistency is not related to citizenship or immigration status.
- (c) An applicant shall not be required to provide information beyond the minimum necessary to support the eligibility and enrollment processes of the Exchange, Medi-Cal, and CHIP.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502, 100503, and 100504, Government Code; 45 CFR § 155.315.

§ 6494. Special Eligibility Standards and Verification Process for Indians.

- (a) An Indian applicant's eligibility for CSR shall be determined based on the following procedures.
 - (1) An Indian applicant shall be eligible for CSR if he or she:
 - (A) Meets the eligibility requirements specified in Sections 6472 and 6474(c);
 - (B) Is expected to have a household income, as defined in section 36B(d)(2) of IRC (26 U.S.C. § 36B(d)(2)) and in 26 CFR § 1.36B-1(e), that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested; and
 - (C) Is enrolled in a QHP through the Exchange.
 - (2) If an Indian applicant meets the eligibility requirements of paragraph (a)(1):
 - (A) Such applicant shall be treated as an eligible insured; and
 - (B) The QHP issuer shall eliminate any cost-sharing under the plan.
 - (3) Regardless of an Indian applicant's income and the requirement of Section 6476(b) to request an eligibility determination for all IAPs, such applicant shall be eligible for CSR if the individual is:
 - (A) Enrolled in a QHP through the Exchange; and
 - (B) Furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.
 - (4) If an Indian applicant meets the requirements of paragraph (a)(3) of this section, the QHP issuer:

(A) Shall eliminate any cost-sharing under the plan for the item or service specified in paragraph (a)(3)(B); and

(B) Shall not reduce the payment to any such entity for the item or service specified in paragraph (a)(3)(B) by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

(b) An Indian applicant's attestation that he or she is an Indian shall be verified by:

- (1) Using any relevant documentation verified in accordance with Section 6492;
- (2) Relying on any HHS-approved electronic data sources that are available to the Exchange; or
- (3) If HHS-approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an applicant's attestation:

(A) Following the procedures specified in Section 6492; and

(B) Verifying documentation provided by the applicant that meets the following requirements for satisfactory documentary evidence of citizenship or nationality:

- i. Except as provided in subclause (ii), a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).
- ii. With respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, such other forms of documentation (including tribal documentation, if appropriate) that HHS has determined to be satisfactory documentary evidence of citizenship or nationality.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.350.

§ 6496. Eligibility Redetermination during a Benefit Year.

- (a) The Exchange shall redetermine the eligibility of an enrollee in a QHP through the Exchange during the benefit year if it receives and verifies new information reported by an enrollee or identifies updated information through the data matching described in paragraph (g) of this section.

- (b) Except as specified in paragraphs (c) and (d) of this section, an enrollee, or an application filer on behalf of the enrollee, shall report any change of circumstances with respect to the eligibility standards specified in Sections 6472 and 6474 within 30 days of such change. Changes shall be reported through any of the ~~channels available for the submission of an application, as described in Section 6470(d)~~ following channels:
- (1) The Exchange Internet Web site;
 - (2) Telephone;
 - (3) Faxcimile;
 - (4) Mail; or
 - (5) In person.
- (c) An enrollee who has not requested an eligibility determination for IAPs shall not be required to report changes that affect eligibility for IAPs.
- (d) An enrollee who experiences a change in income that ~~is less than 10 percent of the income used in the enrollee's most recent eligibility determination is~~ does not impact the amount of the enrollee's APTC or the level of CSR for which he or she is eligible shall not be required to report such a change.
- (e) The reported changes shall be verified in accordance with the process specified in Sections 6478 through 6492 before such information shall be used in an eligibility determination.
- (f) The Exchange shall provide electronic notifications to an enrollee who has elected to receive electronic notifications, unless he or she has declined to receive notifications under this paragraph, regarding the requirements for reporting changes and the enrollee's opportunity to report any changes as described in paragraph (d) of this section.
- (g) The Exchange shall examine available data sources on a semiannual basis to identify the following changes of circumstances:
- (1) Death;
 - (2) Household income changes; and
 - (3) Eligibility determinations for Medicare, Medi-Cal, or CHIP.
- (h) For verification of the enrollee-reported data, the Exchange shall:
- (1) Redetermine the enrollee's eligibility in accordance with the standards specified in Sections 6472 and 6474;

- (2) Notify the enrollee regarding the determination, in accordance with the requirements specified in Section 6476(g); and
- (3) Notify the enrollee's employer, as applicable, in accordance with the requirements specified in Section 6476(h).
- (i) For verification of updated information that the Exchange identifies through semiannual data matching not regarding income, family size, and family composition, the Exchange shall:
 - (1) Notify the enrollee regarding the updated information, as well as the enrollee's projected eligibility determination after considering such information;
 - (2) Allow an enrollee 30 days from the date of the notice described in paragraph (i)(1) to notify the Exchange that such information is inaccurate;
 - (3) If the enrollee responds contesting the updated information, proceed in accordance with Section 6492; and
 - (4) If the enrollee does not respond within the 30-day period specified in paragraph (i)(2), proceed in accordance with paragraphs (h)(1) and (2) of this section.
- (j) For verification of updated information that the Exchange identifies through semiannual data matching regarding income, family size, and family composition, the Exchange shall:
 - (1) Follow procedures described in paragraph (i)(1) and (2) of this section;
 - (2) If the enrollee responds confirming the updated information or providing more up to date information, proceed in accordance with paragraphs (h)(1) and (2) of this section; and
 - (3) If the enrollee does not respond within the 30-day period specified in paragraph (i)(2) of this section, maintain the enrollee's existing eligibility determination without considering the updated information.
- (k) Except as specified in paragraphs (l) or (m) of this section, the Exchange shall implement changes resulting from a redetermination under this section on the first day of the month following the date of the redetermination notice described in paragraph (h)(2) of this section.
- (l) Changes captured through a redetermination on or after the sixteenth day of any month shall be effective on the first day of the second month following the date of the redetermination notice described in paragraph (h)(2) ~~after the month specified in paragraph (k) of this section.~~
- (m) In the case of a redetermination that results in an enrollee being ineligible to continue his or her enrollment in a QHP through the Exchange:

- (1) The enrollee's QHP coverage through the Exchange shall be terminated, as specified in Section 6506(b)(1); and
 - (2) The Exchange shall maintain the enrollee's eligibility for enrollment in a QHP without APTC and CSR until the effective dates of the termination of coverage, as specified in Section 6506(d)(3).
- (n) In the case of a redetermination that results in a change in the amount of APTC for the benefit year, the Exchange shall recalculate the amount of APTC in such a manner as to:
- (1) Account for any APTC already made on behalf of the tax filer for the benefit year for which information is available to the Exchange, such that the recalculated APTC amount is projected to result in total APTC for the benefit year that correspond to the tax filer's total projected APTC for the benefit year, calculated in accordance with Section 36B of IRC (26 U.S.C. § 36B) and 26 CFR § 1.36B-3; and
 - (2) Ensure that the APTC provided on the tax filer's behalf is equal to or greater than zero and is calculated in accordance with Section 36B(b) of IRC (26 U.S.C. § 36B(b)) and 26 CFR 1.36B-3(d).
- (o) In the case of a redetermination that results in a change in CSR, the Exchange shall determine an individual eligible for the category of CSR that corresponds to his or her expected annual household income for the benefit year, subject to the special rule for family policies set forth in Section 6474(d)(4).

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.330.

§ 6498. Annual Eligibility Redetermination.

- (a) Except as specified in paragraph (d) of this section, the Exchange shall redetermine the eligibility of an enrollee in a QHP through the Exchange on an annual basis in accordance with the timing described in paragraph (f) of this section.
- (b) To conduct an annual redetermination, the Exchange shall have on file an active authorization from an enrollee to obtain updated tax return information described in paragraph (c) of this section. This authorization shall be for a period of no more than five years based on a single authorization, provided that an individual may:
 - (1) Decline to authorize the Exchange to obtain updated tax return information; or
 - (2) Authorize the Exchange to obtain updated tax return information for up to five years; and
 - (3) Discontinue, change, or renew his or her authorization at any time.

- (c) If an enrollee requested an eligibility determination for IAPs on the original application, in accordance with Section 6476(a) and (b), and the Exchange has an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange shall request:
- (1) Updated tax return information through HHS, as described in Section 6482(b) and (c); and
 - (2) Data regarding MAGI-based income, ~~as described in Section 6488(d)~~ in accordance with the process specified in Medicaid regulations at 42 CFR § 435.948(a).
- (d) If an enrollee requested an eligibility determination for IAPs on the original application, in accordance with Section 6476(a) and (b), and the Exchange does not have an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange:
- (1) Shall notify the enrollee in accordance with the timing described in paragraph (f) of this section; and
 - (2) Shall not proceed with the redetermination process described in paragraphs (e) and (g) through (m) of this section until such authorization has been obtained or the enrollee withdraws his or her request for an eligibility determination for IAPs.
- (e) The Exchange shall provide an enrollee with an annual redetermination notice with a pre-populated form that includes:
- (1) Data obtained under paragraph (c) of this section, if applicable;
 - (2) Data used in the enrollee's most recent eligibility determination; and
 - (3) The enrollee's projected eligibility determination for the following year, after considering any updated information described in paragraph (e)(1) of this section, including, if applicable, the amount of any APTC and the level of any CSR or eligibility for Medi-Cal or CHIP.
- (f) For eligibility redeterminations under this section, the Exchange shall provide the annual redetermination notice, as specified in paragraph (e) of this section, and the notice of annual open enrollment period, as specified in Section 6502(e), through a single, coordinated notice.
- (g) An enrollee, or an application filer on behalf of the enrollee, shall report to the Exchange any changes with respect to the information listed in the notice described in paragraph (e) of this section within 30 days from the date of the notice, using any of the channels ~~available for the submission of an application, as described in Section 6470(d)~~ specified in Section 6496(b).
- (h) The Exchange shall verify any information reported by an enrollee under paragraph (g) of this section using the processes specified in Sections 6478 through 6492, prior to using such information to determine eligibility.

- (i) An enrollee, or an application filer on behalf of the enrollee, shall sign and return the notice described in paragraph (e) of this section. If an enrollee does not sign and return the notice described in paragraph (e) of this section within the 30-day period specified in paragraph (g) of this section, the Exchange shall proceed in accordance with the procedures specified in paragraph (j) of this section.
- (j) After the 30-day period specified in paragraph (g) of this section has elapsed, the Exchange shall:
 - (1) Redetermine the enrollee's eligibility in accordance with the standards specified in Sections 6472 and 6474 using the information provided to the individual in the notice specified in paragraph (e), as supplemented with any information reported by the enrollee and verified by the Exchange in accordance with paragraphs (g) and (h) of this section;
 - (2) Notify the enrollee in accordance with the requirements specified in Section 6476(g); and
 - (3) If applicable, notify the enrollee's employer, in accordance with the requirements specified in Section 6476(h).
- (k) If an enrollee reports a change with respect to the information provided in the notice specified in paragraph (e) of this section that the Exchange has not verified as of the end of the 30-day period specified in paragraph (g) of this section, the Exchange shall redetermine the enrollee's eligibility after completing verification, as specified in paragraph (h) of this section.
- (l) A redetermination under this section shall be effective on the first day of the coverage year following the year in which the Exchange provided the notice in paragraph (e) of this section, or in accordance with the rules specified in Section 6496(k) through (m), whichever is later.
- (m) If an enrollee remains eligible for coverage in a QHP upon annual redetermination, such enrollee shall remain in the QHP selected the previous year unless he or she terminates coverage from such plan, including termination of coverage in connection with enrollment in a different QHP, in accordance with Section 6506.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.335.

§ 6500. Enrollment of Qualified Individuals into QHPs.

- (a) A qualified individual may enroll in a QHP (and an enrollee may change QHPs) only during, and in accordance with the coverage effective dates related to, the following periods:
 - (1) The initial open enrollment period, as specified in Section 6502;

- (2) The annual open enrollment period, as specified in Section 6502; or
- (3) A special enrollment period, as specified in Section 6504, for which the qualified individual has been determined eligible.

~~(b) For purposes of this section, enrollment shall be deemed complete when the applicant's coverage is effectuated, which shall occur when the QHP issuer receives the applicant's initial premium payment in full and by the due date.~~

(b) The Exchange shall accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP in accordance with Section 6472, and shall:

- (1) Notify the applicant of her or his initial premium payment methodology options and of the requirement that the applicant's initial premium payment shall be received in full by the QHP issuer on or before the premium payment due date, as defined in Section 6410 of Article 2 of this chapter, in order for the applicant's coverage to be effectuated, as specified in ~~paragraph (b) of this section~~ Section 6502(g);
- (2) Notify the QHP issuer that the individual is a qualified individual and of the applicant's selected QHP and premium payment methodology option;
- (3) Transmit to the QHP issuer information necessary to enable the issuer to enroll the applicant ~~promptly and without undue delay~~ within three business days from the date the Exchange obtains the information; and
- (4) Transmit eligibility and enrollment information to HHS promptly and without undue delay, in a manner and timeframe as specified by HHS.

(c) The Exchange shall maintain records of all enrollments in QHPs through the Exchange.

(d) The Exchange shall reconcile enrollment information with QHP issuers and HHS no less than once a month.

(e) A QHP issuer shall accept enrollment information specified in paragraph (b) of this section consistent with the privacy and security requirements established by the Exchange in accordance with 45 CFR § 155.260 and in an electronic format that is consistent with 45 CFR § 155.270, and shall:

- (1) Acknowledge receipt of enrollment information transmitted from the Exchange in accordance with the standards established by the Exchange;

- (2) Enroll a qualified individual during the periods specified in paragraph (a) of this section;
 - (3) Notify a qualified individual of his or her premium payment due date;
 - (4) Abide by the effective dates of coverage established by the Exchange in accordance with Section 6502(c) and (f) and Section 6504(g) and (h);
 - (5) Notify the Exchange of the issuer's timely receipt of a qualified individual's initial premium payment and his or her effective date of coverage;
 - (6) Notify a qualified individual of his or her effective date of coverage upon the timely receipt of the individual's initial premium payment; and
 - (7) Provide new enrollees an enrollment information package that is compliant with accessibility and readability standards specified in Section 6452 of Article 4 of this chapter.
- (f) If an applicant initiates enrollment directly with a QHP issuer for enrollment through the Exchange, the QHP issuer shall either:
- (1) Direct the individual to file an application with the Exchange, or
 - (2) Assist the applicant, upon the applicant's request, to apply for and receive an eligibility determination for coverage through the Exchange through the Exchange Internet Web site.
- (g) A QHP issuer shall follow the premium payment process established by the Exchange.
- (h) A QHP issuer shall reconcile enrollment and premium payment files with the Exchange no less than once a month.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR §§ 155.400, 156.260, and 156.265.

§ 6502. Initial and Annual Open Enrollment Periods.

- (a) A qualified individual shall enroll in a QHP, or an enrollee shall change QHPs, only during the initial open enrollment period, as specified in paragraph (b) of this section, the annual open enrollment period, as specified in paragraph (d) of this section, or a special enrollment period, as described in Section 6504, for which the qualified individual has been determined eligible.
- (b) The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014.

(c) Regular coverage effective dates for initial open enrollment period for a QHP selection received by the Exchange from a qualified individual:

(1) On or before December 15, 2013, shall be January 1, 2014;

(2) Between the first and fifteenth day of any subsequent month during the initial open enrollment period, shall be the first day of the following month; and

(3) Between the sixteenth and last day of the month for any month between December 2013 and March 31, 2014, shall be the first day of the second following month.

(d) Annual open enrollment period for benefit years beginning on or after January 1, 2015, begins October 15 and extends through December 7 of the preceding calendar year.

(e) Beginning 2014, the Exchange shall provide a written annual open enrollment notification to each enrollee no earlier than September 1 and no later than September 30.

(f) For a qualified individual who has made a QHP selection during the annual open enrollment period, the coverage effective date shall be the first day of the following benefit year.

(g) A qualified individual's coverage shall be effectuated in accordance with the coverage effective dates specified in paragraphs (c) and (f) of this section if:

(1) The individual makes his or her initial premium payment in full by the premium payment due date, as defined in Section 6410 of Article 2 of this chapter; and

(2) The applicable QHP issuer receives such payment on or before such due date.

~~(g) The initial premium payment shall be made by a qualified individual and received by the QHP issuer by the end of the month prior to the coverage effective dates specified in paragraphs (c) and (f) of this section.~~

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.410.

§ 6504. Special Enrollment Periods.

(a) A qualified individual may enroll in a QHP, or an enrollee may change QHP, during special enrollment periods only if one of the following triggering events occurs:

- (1) A qualified individual or dependent loses MEC, as specified in paragraph (b) of this section;
 - (2) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption;
 - (3) An individual who was not previously a citizen, national, or lawfully present individual gains such status;
 - (4) A qualified individual's, or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange shall take necessary actions to correct or eliminate the effects of such error, misrepresentation, or inaction;
 - (5) An enrollee, or his or her dependent, adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
 - (6) An enrollee is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR;
 - (7) An individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value, as described in section 36B(c)(2)(C) of IRC (26 U.S.C. § 36B(c)(2)(C)) and in 26 CFR § 1.36B-2(c)(3)(v) and (vi), for his or her employer's upcoming plan year is determined newly eligible for APTC. Such individual may access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
 - (8) A qualified individual or enrollee gains access to new QHPs as a result of a permanent move, which shall also apply to individuals who are released from incarceration; and
 - (9) A qualified individual who is an Indian, as defined in Section 6410 of Article 2 of this chapter, may enroll in a QHP or change from one QHP to another one time per month.
- (b) Loss of MEC, as specified in paragraph (a)(1) of this section, includes:
- (1) Loss of eligibility for coverage, including but not limited to:

- (A) Loss of eligibility for coverage as a result of:
- i. Legal separation,
 - ii. Divorce,
 - iii. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan),
 - iv. Death of an employee,
 - v. Termination of employment,
 - vi. Reduction in the number of hours of employment, and
 - vii. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
- (B) Loss of eligibility for coverage through Medicare, Medi-Cal, or other government-sponsored health care programs;
- (C) In the case of coverage offered through an HMO or similar program in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
- (D) In the case of coverage offered through an HMO or similar program in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
- (E) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
- (F) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.
- (2) Termination of employer contributions toward the employee's or dependent's coverage that is not COBRA continuation coverage, including contributions by any current or former employer that was contributing to coverage for the employee or dependent; and
- (3) Exhaustion of COBRA continuation coverage, meaning that such coverage ceases:

- (A) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
 - (B) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or
 - (C) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.
- (c) Loss of MEC, as specified in paragraph (a)(1) of this section, does not include termination or loss due to:
- (1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or
 - (2) Termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with a plan.
- (d) A qualified individual or an enrollee shall attest that he or she meets at least one of the triggering events specified in paragraph (a) of this section.
- (e) The Exchange shall accept a qualified individual's or an enrollee's attestation provided in accordance with paragraph (d) of this section without further verification. ~~verify any information or documentation provided by an applicant or an enrollee under paragraph (d) of this section in accordance with the process specified in Sections 6478 through 6492 before such information shall be used to determine eligibility for a special enrollment period.~~
- (f) A qualified individual or enrollee shall have 60 days from the date of one of the triggering events specified in paragraph (a) of this section to select a QHP.
- (g) Except as specified in paragraph (h) of this section, regular coverage effective dates for special enrollment period for a QHP selection received by the Exchange from a qualified individual:
- (1) Between the first and fifteenth day of any month, shall be the first day of the following month; and

- (2) Between the sixteenth and last day of any month, shall be the first day of the second following month.

(h) Special coverage effective dates shall apply to the following situations.

- (1) In the case of birth, adoption or placement for adoption:

- (A) The coverage shall be effective on the date of birth, adoption, or placement for adoption; and

- (B) APTC and CSR, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and

- (2) In the case of marriage, or in the case where a qualified individual loses MEC, as described in paragraph (a)(1) of this section, the coverage and APTC and CSR, if applicable, shall be effective on the first day of the following month.

~~(i) The initial premium payment shall be made by a qualified individual and received by the QHP issuer by the end of the month prior to the coverage effective dates specified in paragraphs (f), (g) and (h) of this section.~~

(i) A qualified individual's coverage shall be effectuated in accordance with the coverage effective dates specified in paragraphs (g) and (h) of this section if:

- (1) The individual makes his or her initial premium payment in full by the premium payment due date, as defined in Section 6410 of Article 2 of this chapter; and

- (2) The applicable QHP issuer receives such payment on or before such due date.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.420.

§ 6506. Termination of Coverage in a QHP.

- (a) An enrollee may terminate his or her coverage in a QHP, including as a result of the enrollee obtaining other MEC, with appropriate notice to the Exchange.
- (b) The Exchange may initiate termination of an enrollee's coverage in a QHP, and shall permit a QHP issuer to terminate such coverage, provided that the issuer makes reasonable accommodations for all individuals with disabilities (as defined by the Americans with

Disabilities Act) before terminating coverage for such individuals, under the following circumstances:

- (1) The enrollee is no longer eligible for coverage in a QHP through the Exchange;
 - (2) The enrollee fails to pay premiums for coverage, as specified in paragraph (c) of this section, and:
 - (A) The three-month grace period required for individuals receiving APTC has been exhausted, as described in paragraph (c)(2) and (3) of this section; or
 - (B) Any other grace period not described in paragraph (b)(2)(A) of this section has been exhausted;
 - (3) The enrollee's coverage is rescinded by the QHP issuer because the enrollee has made a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan;
 - (4) The QHP terminates or is decertified as described in 45 CFR § 155.1080; or
 - (5) The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period in accordance with Sections 6502 and 6504.
- (c) In the case of termination of enrollee's coverage due to non-payment of premium, as specified in paragraph (b)(2) of this section, a QHP issuer shall:
- (1) Provide the enrollee, who is delinquent on premium payment, with notice of such payment delinquency;
 - (2) Provide a grace period of three consecutive months if an enrollee receiving APTC has previously paid at least one full month's premium during the benefit year;
 - (3) During the grace period specified in paragraph (c)(2):
 - (A) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period;
 - (B) Notify the Exchange and HHS of such non-payment;
 - (C) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period; and

- (D) Continue to collect APTC on behalf of the enrollee from the IRS; and
- (4) If an enrollee receiving APTC exhausts the three-month grace period specified in paragraph (c)(2) of this section without paying all outstanding premiums:
 - (A) Terminate the enrollee's coverage on the effective date described in paragraph (d)(4) of this section, provided that the QHP issuer meets the notice requirements specified in paragraph (e)(1) and (2) of this section; and
 - (B) Return APTC paid on behalf of such enrollee for the second and third months of the grace period.
- (d) If an enrollee's coverage in a QHP is terminated for any reason, the following effective dates for termination of coverage shall apply.
 - (1) For purposes of this paragraph, reasonable notice is defined as 14 days from the requested effective date of termination.
 - (2) In the case of a termination in accordance with paragraph (a) of this section, the last day of coverage shall be:
 - (A) The termination date specified by the enrollee, if the enrollee provides reasonable notice;
 - (B) Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice;
 - (C) On a date determined by the enrollee's QHP issuer, if the enrollee's QHP issuer is able to effectuate termination in fewer than 14 days and the enrollee requests an earlier termination effective date; or,
 - (D) If the enrollee is newly eligible for Medi-Cal or CHIP, the day before such coverage begins.
 - (3) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of coverage shall be the last day of the month following the month in which the notice described in Section 6496(h)(2) is sent by the Exchange unless the individual requests an earlier termination effective date per paragraph (a) of this section.
 - (4) In the case of a termination in accordance with paragraph (b)(2)(A) of this section, the last day of coverage shall be the last day of the first month of the three-month grace period.

- (5) In the case of a termination in accordance with paragraph (b)(2)(B) of this section, the last day of coverage shall be consistent with existing California laws regarding grace periods.
 - (6) In the case of a termination in accordance with paragraph (b)(5) of this section, the last day of coverage in an enrollee's prior QHP shall be the day before the effective date of coverage in his or her new QHP.
- (e) If an enrollee's coverage in a QHP is terminated for any reason, the QHP issuer shall:
- (1) Provide the enrollee with a notice of termination of coverage that includes the reason for termination and the Exchange-approved appeals language at least 30 days prior to the last day of coverage, consistent with the effective date established by the Exchange in accordance with paragraph (d) of this section;
 - (2) Notify the Exchange of the termination effective date and reason for termination; and
 - (3) Maintain records of termination of coverage in accordance with the Exchange standards.
- (f) If an enrollee's coverage in a QHP is terminated for any reason, the Exchange shall:
- (1) Send termination information to the QHP issuer within three business days from the date of the termination;
 - (2) Send termination information to HHS promptly and without undue delay, in a manner and timeframe as specified by HHS; and
 - (3) Retain records of termination of coverage in order to facilitate audit functions.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR §§ 155.430 and 156.270.

~~§ 6508. Appeals of Eligibility Determinations for the Exchange Participation.~~

§ 6508. Authorized Representative. (Discussion Item Only)

- (a) The Exchange shall permit an individual or employee, subject to applicable privacy and security requirements, to designate an individual or organization to act on his or her behalf in applying for an eligibility determination or redetermination and in carrying out other ongoing communications with the Exchange.
- (b) Designation of an authorized representative shall be in writing, including a signature or through another legally binding format subject to applicable authentication and data security standards. If submitted, legal documentation of authority to act on behalf of an individual

under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of the applicant's signature.

- (c) The authorized representative shall agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the individual or employee provided by the Exchange.
- (d) The authorized representative shall be responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in paragraph (f) of this section, to the same extent as the individual he or she represents.
- (e) The Exchange shall permit an individual or employee to designate an authorized representative at the time of application or at other times and through methods described in Section 6470(e).
- (f) The Exchange shall permit an individual to authorize their representative to:
 - (1) Sign an application on the individual's behalf;
 - (2) Submit an update or respond to a redetermination for the individual in accordance with Sections 6496 and 6498;
 - (3) Receive copies of the individual's notices and other communications from the Exchange; and
 - (4) Act on behalf of the individual in all other matters with the Exchange.
- (g) The Exchange shall consider an authorized representative valid until the applicant or enrollee:
 - (1) Modifies the authorization;
 - (2) Notifies the Exchange and the representative that the representative is no longer authorized to act on his or her behalf using one of the methods available for the submission of an application, as described in Section 6470(e); or
 - (3) The authorized representative informs the Exchange and the individual that he or she no longer is acting in such capacity.
- (h) When an organization is designated as an authorized representative, staff or volunteers of that organization that exercise that capacity for an applicant before the Exchange and the organization itself shall enter into an agreement with the Exchange to comply with the certification requirements set forth by the Exchange.

- (i) An authorized representative shall comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.
- (j) For purposes of this section, designation of an authorized representative shall be in writing including a signature or through another legally binding format and be accepted through all of the methods described in Section 6470(e).

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100502 and 100503, Government Code; 45 CFR § 155.227, as proposed on Jan. 22, 2013.

§ 6510. Right to Appeal. (Discussion Item Only)

The Exchange shall include the notice of the right to appeal and instructions regarding how to file an appeal in accordance with Article 7 of this chapter in any eligibility determination notice issued to the applicant in accordance with Sections 6476(g), 6496(h)(2), or 6498(j)(2).

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR § 155.355.

California Code of Regulations

Title 10. Investment

Chapter 12. California Health Benefit Exchange (§ 6400 et seq.)

Article 7. Appeals Process.

§ 6600. Definitions. **(Discussion Item Only)**

In addition to the definitions in Section 6410 of Article 2 of this chapter, for purposes of this Article, the following terms shall mean:

Appeal record: The appeal decision, all papers and requests filed in the proceeding, and, if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing and any exhibits introduced at the hearing.

Appeal request: A clear expression, either orally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have any eligibility determination or redetermination contained in a notice issued in accordance with Sections 6476(g), 6496(h)(2), 6498(j)(2) of Article 5 of this chapter, Section 155.715(e) or (f) (placeholder for Eligibility Determination Process for SHOP reg), or pursuant to future federal guidance on exemptions in accordance with Section 1311(d)(4)(H) of the Affordable Care Act, reviewed by an appeals entity.

Appeals entity: A body designated to hear appeals of eligibility determinations or redeterminations contained in notices issued in accordance with Sections 6476(g), 6496(h)(2), 6498(j)(2) of Article 5 of this chapter, Section 155.715(e) or (f) (placeholder for Eligibility Determination Process for SHOP reg), or notices issued in accordance with future federal guidance on exemptions pursuant to Section 1311(d)(4)(H).

Appellant: The applicant or enrollee, the employer, or the small business employer or employee who is requesting an appeal.

De novo review: A review of an appeal without deference to prior decisions in the case.

Evidentiary hearing: A hearing conducted where new evidence may be presented.

Vacate: To set aside a previous action.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR § 155.500, as proposed on Jan. 22, 2013.

§ 6602. General Eligibility Appeals Requirements.

- (a) In accordance with Section 6510 of Article 5 of this chapter and future federal guidance on exemptions pursuant to Section 1311(d)(4)(H) of the Affordable Care Act, an applicant or enrollee shall have the right to appeal:
 - (1) An eligibility determination made in accordance with Article 5 of this chapter, including:
 - (A) An initial determination of eligibility, including the amount of APTC and level of CSR, made in accordance with the standards specified in Sections 6472 and 6474 of Article 5 of this chapter; and
 - (B) A redetermination of eligibility, including the amount of APTC and level of CSR, made in accordance with Sections 6496 and 6498 of Article 5 of this chapter;
 - (2) An eligibility determination for an exemption made in accordance with future federal guidance on exemptions pursuant to section 1311(d)(4)(H) of the Affordable Care Act; and
 - (3) The Exchange's failure to provide timely notice of an eligibility determination in accordance with Sections 6476(g), 6496(h)(2), or 6498(j)(2) of Article 5 of this chapter.
- (b) The Exchange eligibility appeals may be conducted by the Exchange or HHS upon exhaustion of the Exchange appeals process.
- (c) An appellant may designate an authorized representative to act on his or her behalf, including in making an appeal request, as provided in Section 6508 of Article 5 of this chapter.
- (d) Appeals processes established under this Article shall comply with the accessibility and readability requirements in Section 6452 of Article 4 of this chapter.
- (e) When an appellant seeks review of an adverse MAGI Medi-Cal or CHIP determination made by the Exchange, the appeals entity shall transmit the eligibility determination and all information provided as part of the appeal via secure electronic interface, promptly and without undue delay [placeholder for data/records transmittal timeline], to DHCS, as applicable.
- (f) An appellant may seek judicial review to the extent it is available by law.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR §§ 155.505, 155.510, as proposed on Jan. 22, 2013.

§ 6604. Notice of Appeal Procedures. (Discussion Item Only)

(a) The Exchange shall provide notice of appeal procedures at the time that the:

- (1) Applicant submits an application; and
- (2) Exchange sends notice of eligibility determination in accordance with Sections 6476(g), 6496(h)(2), or 6498(j)(2) of Article 5 of this chapter, or future federal guidance on exemptions pursuant to Section 1311(d)(4)(H) of the Affordable Care Act.

(b) Notices described in paragraph (a) of this section shall contain:

- (1) An explanation of the applicant or enrollee's appeal rights under this Article;
- (2) A description of the procedures by which the applicant or enrollee may request an appeal;
- (3) Information on the applicant or enrollee's right to represent himself or herself, or to be represented by legal counsel or an authorized representative, as provided in Section 6508 of Article 5 of this chapter;
- (4) An explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision, as provided in Section 6608; and
- (5) An explanation that an appeal decision for one household member may result in a change in eligibility for other household members and may be handled as a redetermination in accordance with the standards specified in Sections 6472 and 6474 of Article 5 of this chapter.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR § 155.515, as proposed on Jan. 22, 2013.

§ 6606. Appeal Requests. (Discussion Item Only)

(a) The Exchange and the appeals entity:

- (1) Shall accept appeal requests submitted:
 - (A) By telephone;
 - (B) By mail;

(C) In person, if the Exchange or the appeals entity, as applicable, is capable of receiving in-person appeal requests; or

(D) Via the Internet.

(2) May assist the applicant or enrollee in making the appeal request;

(3) Shall not limit or interfere with the applicant or enrollee's right to make an appeal request; and

(4) Shall consider an appeal request to be valid for the purpose of this Article, if it is submitted in accordance with the requirements of paragraphs (b) and (c) of this section and Section 6602(a).

(b) The Exchange and the appeals entity shall allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of eligibility determination.

(c) If the appellant disagrees with the appeal decision of the Exchange appeals entity, he or she may make an appeal request to HHS within 30 days of the date of the Exchange appeals entity's notice of appeal decision through any of the methods described in paragraph (a)(1) of this section.

(d) Upon receipt of a valid appeal request pursuant to paragraphs (b) or (f) of this section, the appeals entity:

(1) Shall send timely acknowledgment to the appellant of the receipt of his or her valid appeal request, including:

(A) Information regarding the appellant's eligibility pending appeal pursuant to Section 6608; and

(B) An explanation that any APTC paid on behalf of the tax filer pending appeal are subject to reconciliation under Section 36B(f) of IRC (26 U.S.C. § 36B(f)) and 26 CFR § 1.36B-4;

(2) Shall send timely notice via secure electronic interface of the appeal request and, if applicable, instructions to provide eligibility pending appeal pursuant to Section 6608, to the Exchange and to the DHCS, where applicable; and

- (3) Shall promptly confirm receipt of the records transferred by the Exchange pursuant to paragraph (f) of this section.
- (e) Upon receipt of an appeal request that is not valid because it fails to meet the requirements of this section or Section 6602(a), the appeals entity shall:
- (1) Promptly and without undue delay [placeholder for specified timeline], send written notice to the applicant or enrollee that the appeal request has not been accepted and of the nature of the defect in the appeal request; and
 - (2) Treat as valid an amended appeal request that meets the requirements of this section and of Section 6602(a).
- (f) Upon receipt of a valid appeal request pursuant to paragraph (b) of this section, or upon receipt of the notice under paragraph (d)(2) of this section, the Exchange shall transmit via secure electronic interface to the appeals entity:
- (1) The appeal request, if the appeal request was initially made to the Exchange; and
 - (2) The appellant's eligibility record.
- (g) Upon receipt of the notice of an appeals request made to HHS, pursuant to paragraph (c) of this section, the Exchange appeals entity shall transmit via secure electronic interface the appellant's appeal record, including the appellant's eligibility record as received from the Exchange, to HHS.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR § 155.520, as proposed on Jan. 22, 2013.

§ 6608. Eligibility Pending Appeal. (Discussion Item Only)

- (a) Upon receipt of a valid appeal request or notice under Section 6606(d)(2) that concerns an appeal of a redetermination under Sections 6496(h) or 6498(j) of Article 5 of this chapter, the Exchange shall continue to consider the appellant eligible while the appeal is pending in accordance with standards set forth in paragraph (b) of this section.
- (b) The Exchange shall continue the appellant's eligibility for enrollment in a QHP, APTC, and CSR, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR § 155.525, as proposed on Jan. 22, 2013.

§ 6610. Dismissals. (Discussion Item Only)

- (a) The appeals entity shall dismiss an appeal if the appellant:
- (1) Withdraws the appeal request in writing;
 - (2) Fails to appear at a scheduled hearing;
 - (3) Fails to submit a valid appeal request as specified in Section 6606(a)(4); or
 - (4) Dies while the appeal is pending.
- (b) If an appeal is dismissed under paragraph (a) of this section, the appeals entity shall provide timely notice [placeholder for specified timeline] to the appellant, including:
- (1) The reason for dismissal;
 - (2) An explanation of the dismissal's effect on the appellant's eligibility; and
 - (3) An explanation of how the appellant may show good cause why the dismissal should be vacated in accordance with paragraph (d) of this section.
- (c) If an appeal is dismissed under paragraph (a) of this section, the appeals entity shall provide timely notice [placeholder for specified timeline] to the Exchange, and to the DHCS, as applicable, including instruction regarding:
- (1) The eligibility determination to implement; and
 - (2) Discontinuing eligibility pending appeal provided under Section 6608.
- (d) The appeals entity may vacate a dismissal if the appellant makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR § 155.530, as proposed on Jan. 22, 2013.

§ 6612. Informal Resolution.

- (a) An appellant shall have an opportunity for informal resolution prior to a hearing in accordance with the requirements of this section.

(b) The Exchange informal resolution shall be conducted in accordance with the following process:

(1) Reserved.

(c) The informal resolution process shall comply with the scope of review specified in Section 6614(e).

(d) An appellant's right to a hearing shall be preserved in any case in which the appellant remains dissatisfied with the outcome of the informal resolution process.

(e) If the appeal advances to hearing, the appellant shall not be asked to provide duplicative information or documentation that he or she previously provided during the application or informal resolution process.

(f) If the appeal does not advance to hearing, the informal resolution decision shall be final and binding.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR § 155.535, as proposed on Jan. 22, 2013.

§ 6614. Hearing Requirements. (Discussion Item Only)

(a) An appellant shall have an opportunity for a hearing in accordance with the requirements of this section.

(b) When a hearing is scheduled, the appeals entity shall send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 days prior to the hearing date.

(c) The hearing shall be conducted:

(1) At a reasonable date, time, and location or format;

(2) After notice of the hearing, pursuant to paragraph (b) of this section;

(3) As an evidentiary hearing, consistent with paragraph (e) of this section; and

(4) By one or more impartial officials who have not been directly involved in the eligibility determination or any prior Exchange appeal decisions in the same matter.

- (d) The appeals entity shall provide the appellant with the opportunity to:
- (1) Review his or her appeal record, including all documents and records to be used by the appeals entity at the hearing, at a reasonable time before the date of the hearing as well as during the hearing;
 - (2) Bring witnesses to testify;
 - (3) Establish all relevant facts and circumstances;
 - (4) Present an argument without undue interference; and
 - (5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.
- (e) The appeals entity shall consider the information used to determine the appellant's eligibility as well as any additional relevant evidence presented during the course of the appeal, including at the hearing.
- (f) The appeals entity shall review the appeal *de novo* and shall consider all relevant facts and evidence adduced during the appeal.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR § 155.535, as proposed on Jan. 22, 2013.

§ 6616. Expedited Appeals. (Discussion Item Only)

- (a) The appeals entity shall establish and maintain an expedited appeals process for an appellant to request an expedited process where there is an immediate need for health services because a standard appeal could seriously jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function.
- (b) If the appeals entity denies a request for an expedited appeal, it shall:
- (1) Handle the appeal request under the standard process and issue the appeal decision in accordance with Section 6618(b)(1); and
 - (2) Make reasonable efforts to inform the appellant through electronic or oral notification of the denial and, if notified orally, follow up with the appellant by written notice within 2 days of the denial.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR § 155.540, as proposed on Jan. 22, 2013.

§ 6618. Appeal Decisions. (Discussion Item Only)

(a) Appeal decisions shall:

- (1) Be based exclusively on the information and evidence specified in Section 6614(e) and the eligibility requirements under Article 5 of this chapter or pursuant to future federal guidance on section 1311(d)(4)(H) of the Affordable Care Act, as applicable;
- (2) State the decision, including a plain language description of the effect of the decision on the appellant's eligibility;
- (3) Summarize the facts relevant to the appeal;
- (4) Identify the legal basis, including the regulations that support the decision;
- (5) State the effective date of the decision; and
- (6) Provide an explanation of the appellant's right to pursue the appeal at HHS if the appellant remains dissatisfied with the eligibility determination.

(b) The appeals entity shall:

- (1) Issue written notice of the appeal decision to the appellant within 90 days (the Exchange has requested HHS an extended 120-day timeframe so that an appropriate and effective informal resolution process can be implemented) of the date an appeal request under Section 6606(b) is received, as administratively feasible;
- (2) In the case of an appeal request submitted under Section 6616 that the appeals entity determines meets the criteria for an expedited appeal, issue the notice as expeditiously as the appellant's health condition requires, but no later than 3 working days after the appeals entity receives the request for an expedited appeal; and
- (3) Provide notice of the appeal decision and instructions to cease the appellant's pended eligibility, if applicable, via secure electronic interface, to the Exchange or the DHCS, as applicable.

(c) Upon receiving the notice described in paragraph (b) of this section, the Exchange shall promptly:

(1) Implement the appeal decision:

(A) Retroactive to the date the incorrect eligibility determination was made;

(B) At a time determined under Section 6496(k) through (m) of Article 5 of this chapter, as applicable; or

(C) In accordance with the applicable Medi-Cal or CHIP standards in 42 CFR parts 435 or 457; and

(2) Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in Section 6472 and 6474 of Article 5 of this chapter.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR § 155.545, as proposed on Jan. 22, 2013.

§ 6620. Appeal Record. (Discussion Item Only)

(a) Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeals entity shall make the appeal record accessible to the appellant at a convenient place and time.

(b) The appeals entity shall provide public access to all appeal records, subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR § 155.550, as proposed on Jan. 22, 2013.

§ 6622. Employer Appeals Process. (Discussion Item Only)

(a) The provisions of this section apply to employer appeals processes through which an employer may, in response to a notice under Section 6476(h) of Article 5 of this chapter, appeal a determination that the employer does not provide MEC through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee.

(b) An employer who seeks an appeal pursuant to paragraph (a) of this section shall request such an appeal directly to HHS in accordance with the process established by HHS.

NOTE: Authority: Section 100504, Government Code. Reference: Sections 100503 and 100506, Government Code; 45 CFR § 155.555, as proposed on Jan. 22, 2013.

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